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DRUG ABUSE—PREVENTION, EDUCATION, AND TREATMENT

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SECOND

ON

EXAMINING THE ISSUES INVOLVED AND APPROACHES BEING TAKEN IN REGARDS TO PREVENTION, EDUCATION, AND TREATMENT IN DEALING WITH DRUG PROBLEMS THROUGHOUT THE NATION

JUNE 16, 1988

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DRUG ABUSE—PREVENTION, EDUCATION AND TREATMENT

THURSDAY, JUNE 16, 1988

U.S. Senate,
Committee on Labor and Human Resources,
Washington, DC.

The Committee met, pursuant to notice, at 10:17 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Hatch, Weicker, Harkin, Simon, Pell, Stafford, Thurmond, Dodd, Adams, and Metzenbaum.

OPENING STATEMENT OF SENATOR KENNEDY

The Chairman. We'll come to order.

I want to welcome our witnesses this morning to this hearing by the Labor and Human Resources Committee on drug abuse and the issues of prevention, education and treatment.

Earlier this week at the Judiciary Committee, we heard about the street side of the issue. We heard police chiefs and a district attorney describe innovative approaches to rid neighborhoods of illegal drugs.

We heard about "drug bazaars" where buyers are lined up like rush hour traffic at city intersections and where guns proliferate, where children bring home throw-away syringes and discarded drug bags, and parents become unwanted visitors in their own neighborhoods.

But we also heard about how those situations can be reversed as a result of effective policy action, with law enforcement officers destroying the markets where the poison is sold. The result, we were told, is that crime rates go down, drugs disappear, and addicts seek treatment for their habits. In one community in Massachusetts, the demand for treatment rose a full 85 percent as a result of effective police action.

Today, we will hear about the treatment side of the issues, and just how much treatment is and isn't available for those who want help for their addictions. We will hear about the treatments that work and about how much more needs to be done, about some of the important scientific work in the search for a cure for addiction.

We will also hear about prevention and education—what kinds of approaches are being taken now and what can be done more effectively to get the message across, especially to children, that drugs are a dead-end.

It will be nearly impossible to end the drug menace by trying to seal our borders. If, tonight, someone were to wave a magic wand, and tomorrow morning there were no more coca plants, no more marijuana, no more poppies, you would still have millions of users, and it would be only a matter of months before new plants were planted and new crops grown and harvested.

If on the other hand you used your magic wand to eliminate the user population, the supplier would be devastated. It would destroy the cartel. The supply does not exist in a vacuum. It only exists in response to demand. It will always exist if there is a demand. As long as there are billion-dollar profits to be made, criminal entrepreneurs will find a way.

There is only one way to put them out of business—a permanent boycott. If we stop buying, they will stop selling. We need to commit more resources to programs that work and to fund the search for new approaches that will work better.

We need early childhood education, which may be the best vaccine against drug abuse. Our commitment calls for effective, continuing drug education in the schools, and for treatment and rehabilitation for all those who want to lead normal, productive lives, but who are crippled by the burden of addiction.

These are the places where dollars bring us most benefits. A single addict costs the country tens of thousands of dollars over a lifetime in the costs for health care, law enforcement, and economic productivity. Every child we save from drugs is worth far more than the cost of effective anti-drug education, and every addict we bring back from drug dependence is a life saved.

There is one effective weapon against the scourge of drugs: education, early and continuous. Every child we miss is a life at risk, and every day we waste in getting the message to our children is another day of peril for them.

The opening statements of Senators Dodd and Adams will be inserted in the record at this point.

OPENING STATEMENT OF SENATOR CHRISTOPHER J. DODD

Senator Dodd. I want to commend Senator Kennedy for holding this hearing today. The devastation caused by drug abuse in our country is without question. But while the magnitude of the problem is undeniable, the solutions remain elusive. It is all too easy to act on good intentions alone and to support half-baked measures. When the drug issue is highly politicized as it is now, there is a strong tendency to simply throw money at the problem. We all recognize that this issue merits more resources, but we must target funds carefully. I know that today's hearing will point us in the direction of sound, long-term answers.

I also want to recognize the leadership that Reverend Jesse Jackson has provided on this issue. Your long-time commitment to public education, your work with families and communities, and your willingness to take on the issue in every forum have contributed greatly to our Nation's renewed commitment to end the plague of drug abuse.

Here in Congress we've heard a lot in recent months about stopping the supply of drugs into this country, about international interdiction and crop eradication, about zero tolerance and high-profile stakeouts on the high seas. At the high water mark of hasty decision-making, both Houses of Congress have voted to involve the United States Armed Forces in domestic law enforcement operations without considering the tremendous and dangerous precedent this policy sets.

I believe strongly in a comprehensive drug supply interdiction strategy. But in our current focus on supply—which has been big on press coverage but short on results—we are overlooking the vital issue of demand. It does no good to focus on supply, if we do nothing effective about demand. Both sides must be attacked in coordination.

Unfortunately current strategies to reduce demand aren't working. In December of 1987—just six months ago—the GAO gave us bad news: based on available evaluations of current drug prevention programs, they found current drug education to "have virtually no impact on drug abuse or the intent to abuse drugs". We are fooling ourselves if we think that the combination of the present forms of drug education and the "just say no" approach will significantly reduce the demand for drugs in this country. We need to rethink our strategies for prevention and treatment.

Nonetheless, for all that the GAO brought bad news, we do know that many programs work. As Chairman of the Subcommittee on Children, Family, Drugs and Alcoholism, I have received some very encouraging reports. As we in Congress look carefully at where we spend and make hard choices, there are models to follow. We look to you today to add to our knowledge of what works.

My own conclusion, reinforced by the work of the subcommittee, is that the role of the family is key to understanding and stopping the drug abuse epidemic. I believe that the family is both the greatest victim of drug abuse and our greatest weapon against its ravages.

When polled, parents cite drug use as the worst problem facing them and society generally. No wonder, when the 1987 HHS triennial report to Congress on drug abuse projected an increase in overall drug use among high school seniors. No wonder, when virtually all experts see a strong link between teenage suicide and use of illegal drugs.

Parents' deep concern about drug abuse has resulted in some of the most successful programs across the country. We must continue to bring the strengths of the family to bear as we tackle this crisis. How can we better assist parents in educating and supporting their children who are exposed to drugs in the neighborhood and in the school yard? How can we involve entire families in drug treatment programs, thus increasing the likelihood that family members will permanently turn away from drugs? How can we tailor prevention and treatment programs to the particular needs of youth and women?

In recent years we have begun congressional initiatives along these lines. For example, in the 1986 Anti-Drug Abuse Act we set aside funds for children's services and for drug abuse programs designed to serve women, and we included a $20 million high risk youth initiative which I am pleased to say that I authored. Similarly, the Child Abuse and Neglect Act, signed into law earlier this year, establishes a new demonstration grant priority aimed at preventing abuse and neglect of children whose parents are substance abusers.

Such approaches must be continued and expanded in the anti-drug abuse legislation that we enact this year and in the future.

We must also keep in mind that drug abuse does not occur in isolation. It is closely linked with other problems. Patterns of abuse often occur together—child and spousal abuse, alcohol and drug abuse cut across generations within families. The cycle can only be broken to the extent that we invest in people and in families. I am a firm believer in the value of early childhood intervention; programs like Headstart and Chapter I, generate key investments in children "at risk" early on, which pay off many times over in the long run. All the available evidence is that early intervention can help to prevent problems that would otherwise occur later in life, including drug abuse. Federal support for high quality and affordable childcare will increase the chances that our Nation's children will grow up healthy and disinclined to abuse drugs. The same reasoning applies to parental leave, which allows parents to care for their children without losing their jobs.

While strengthening families in these ways, we must also make hard choices on prevention, education and treatment of drug abuse. Next month we will be holding hearings on the family aspects of this problem before the Subcommittee on Children, Family, Drugs and Alcoholism. Today, I thank you for the insights that I know you will provide and for the guidance that your personal experiences and work provide to the targeting of our resources.

OPENING STATEMENT OF SENATOR BROCK ADAMS

Senator ADAMS. I thank the Chairman, Senator Kennedy, for holding these important hearings. Clearly, the drug epidemic is raging out of control all across our nation. It is effecting citizens of every race, color, economic and social background. No longer, either, is it confined to our city streets. Today, the problems of drug addiction, drug violence, and drug related deaths have become common place in every city, town and suburb throughout the nation. Drug abuse, and the violence and human misery associated with it, is no longer someone elses problem—it is our problem—and we are the only ones who can solve it.

Our recent efforts in the war against drugs, though noble, have yielded little success. Local and national news stations continually trumpet reports of yet another major drug bust and police crack down. These are merely the things, however, that make headlines and attract viewer attention—and this can be deceptive. The fact is, we have been largely unsuccessful in our efforts to stop the flow of drugs across our boarders and into the hands of those who cannot or will not stop abusing these substances.

What the American public should know, but is rarely reported, is we have had some success in the area of drug abuse prevention and treatment. As today's witnesses will attest, we are beginning to identify the programs that will enable those who have been snared into addiction to free themselves from the death grip of drugs. With respect to pervention, it is the strength of our drug education programs that have yielded the most startling results. As witnesses on the Education Panel will testify today, those students that are armed with the truth about drugs have the greatest chance of making the correct choice when confronted by those who will try to "turn them on" to drugs.

We must also reach out to those who have fallen prey to the drug epidemic. Many thousands of current drug addicts are crying out for help, yet are unable to access the services necessary to set them free of this demon. To a victim of drug addiction, a waiting list for treatment can mean the difference between life and death. We must commit ourselves to the provision of drug treatment services on demand. While there is no absolute solution, we must continue to support those programs that have achieved success and encourage the development of further initiatives in areas where there is the greatest hope.

As I stated at the outset, the war on drugs is a battle we must fight together. While it will take strong leadership from the top to set the wheels in motion, none of these programs for prevention and treatment will be successful without the commitment of our communities, schools, and parents. Without commitment, our efforts against the drug war will fall flat on their face. Moreover, this commitment must be comprehensive and consistent. We must commit ourselves to address all aspects of the drug crisis until we have achieved total success. That is the message we will hear today and that is what we need to impart to the American public.

I thank the Chairman, once again, for holding this hearing and I look forward to the opportunity to hear the testimony of our distinguished panel of witnesses.

The CHAIRMAN. Our first witness this morning has really been the ambassador to our children on the dangers of drug abuse. Reverend Jesse Jackson has carried the message with eloquence and grace, with vision and with hope, and has given the less fortunate reason to believe in themselves. Win or lose, he has transformed America for the better.

Reverend Jackson, we are honored to have you with us today, and we look forward to hearing your counsel and your advice and your experience.

I recognize the Senator from Utah, Senator Hatch.

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Senator Kennedy.

We are happy to welcome you, Reverend Jackson, and all witnesses who are here today, to continue our work in this Committee's war on drugs.

We have worked together on this issue many times. For example, in 1981, we authorized the Alcohol, Drug Abuse and Mental Health Services Block Grant, which made major changes in the delivery of treatment services. We have refined and reauthorized this program three times.

Then, in 1986, we authored the treatment, prevention, and education provisions of the Anti-Drug Abuse Act of 1986. This emergency legislation included our new School and Community Education Program which increased support for volunteer efforts and expanded treatment programs. In fact, there is strong support in this Committee for the two Federal research institutes, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

In fact, I bring to the Committee's attention some of the fine work done through the ACTION Agency to stimulate community prevention programs. They have done some tremendous work in presenting educational materials and in helping our young people with regard to drugs.

All of this legislation has been developed in a bipartisan fashion, as all of us in the Senate believe that the battle against alcohol and drug abuse is a battle which must be won, and a divided team simply cannot win.

But, Mr. Chairman, we cannot afford to rest on our laurels. Our drug problem is multifaceted and complex. It defies a simple solution. Some think a debate on legalizing dangerous illicit drugs is desirable, but I for one, Mr. Chairman, fail to see how that will save one, single child from the life-threatening trap of drug dependency.

Rather than expending more political hot air debating how to make drugs more available, we ought to continue our focus on eliminating the demand for these weapons of destruction. It is Economics 101—supply will meet the demand, and the demand for drugs in this country has created a mass market.

We have demonstrated, both nationally and in Utah, that education and treatment can make a big difference. The demand for drugs must dry up. We must teach our children that drugs are useless in their lives.

As this chart over here indicates, 47 percent of the American people in a recent Gallup poll believe that reducing the demand for drugs through drug education programs is the single most important thing we can do to halt the drug epidemic. Thirty-five percent believe that stopping the drug flow would be the most important; 6 percent, treatment for users; all three, 13 percent; and 3 percent don't think there is any solution at all.

In devising such programs, we must never lose sight of the fact that drug prevention begins in the home. I have always believed that the way to reduce alcohol and drug abuse is by families working together. Families in America, be they rich or poor, rural or urban, white or black, Native American, Asian or Hispanic, all need our help and our support.

The drug menace and the scum who perpetrate it manage to inflict their pain everywhere in our society. Clearly, we need a one-two punch against suppliers as well. Tough laws and tough law enforcement are an essential part of our battle plan.

But getting tough on drug abuse means more than reconnaissance planes, trained German shepherd dogs, and jail cells. It means denying the pushers their market. It means education, prevention and treatment. We have made much progress in the drug crisis in recent years. Thirty-seven Federal agencies are working together in a vigorous national effort. We have increased seizures of illegal drugs, although more importantly individual use of drugs has dropped. We are making some progress in the area of treatment and prevention, but the battle, in my opinion, has just begun.

On May 18, the President called for a bipartisan effort to develop a comprehensive approach to the drug problem. I hope that we can continue the tradition of bipartisanship we established during the Committee's previous legislative efforts in this area as this new legislation unfolds.

Some have suggested the need for a "Drug Czar" to oversee Federal efforts at eradicating illicit drugs. Reverend Jackson, I understand that a recent article in the New York Times has nominated you as the ideal person for this position because of your passion and your knowledge of the drug problem. So I hope that next January you will consider serving President Bush in that capacity. [Laughter.]

Senator HATCH. I have been wearing Reverend Jackson's button, "Jesse Jackson in 1988", but I'll take it off, because I know you are worried sick——

Reverend JACKSON. Keep it on.

Senator HATCH. Oh, I thought you would be worried sick about the effect it would have on you. [Laughter.]

Seriously, Reverend Jackson, you are a great leader in the war on drugs, and I especially admire the time you spend with our Nation's youth and the things that you have tried to do there.

Reverend JACKSON. Thank you.

Senator HATCH. I hope you will be able to stay a while this morning and listen to one of the truly outstanding drug leaders in Utah, Ms. Colleen Bangerter. She has devoted countless hours travelling throughout our State and working with our young citizens there, and she has enormous determination to beat this problem; in fact, she travelled all night long last night to get here this morning.

This State perspective is, I believe, critical in developing a Federal-State anti-drug coalition.

We are also fortunate to have several other experts with us today, including Mrs. Mary Lou Bozich, who administers the K through 12 Drug Education Program in Utah.

I want to personally thank all of our witnesses for being here today. As front-line warriors in this battle to save our children, they will contribute information and insights vital to the formulation of effective Federal legislative solutions.

Thank you, Mr. Chairman, for holding these hearings. I appreciate the leadership you provide in this area.

The CHAIRMAN. Thank you very much.

[The prepared statement of Senator Hatch follows:]

STATEMENT OF U.S. SENATOR ORRIN G. HATCH
BEFORE THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
HEARING ON DRUG ABUSE, PREVENTION, EDUCATION AND TREATMENT

Mr. Chairman, I am pleased to join you and our distinguished witnesses this morning to continue our Committee's work in the war on drugs.

We have worked together on this issue many times. For example, in 1981, we authored the Alcohol, Drug Abuse and Mental Health Services Block Grant which made major changes in the delivery of treatment services. We have refined and reauthorized this program three times. Then in 1986, we authored the treatment, prevention, and education provisions of the Anti-Drug Abuse Act of 1986. This emergency legislation included our new School and Community Education Program, increased support for volunteer efforts, and expanded treatment programs. In fact, there is strong support in this Committee for the two federal research Institutes, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. In fact, I bring to the Committee's attention some of the fine work done through the ACTION Agency to stimulate community prevention programs. All of the legislation has been developed in a bipartisan fashion, as all of us in the Senate believe in the battle against alcohol and drug abuse is a battle which must be won. A divided team cannot win.

But, Mr. Chairman, we cannot afford to rest on our laurels. Our drug problem is multi-faceted and complex. It defies a simple solution. Some think a debate on legalizing dangerous, illicit drugs is desirable. But, I, for one, Mr. Chairman, fail to see how that will save one single child from the life-threatening trap of drug dependency.

Rather than expending more political hot air debating how to make drugs more available, we ought to continue our focus on eliminating the demand for these weapons of destruction. It's Economics 101--supply will meet the demand, and the demand for drugs in this country has created a mass market. We have demonstrated both nationally, and in Utah, that education and treatment can make a big difference. The demand for drugs must dry up like the demand for pet rocks. We must teach our children that drugs are equally as useless in their lives.

As this chart indicates, 47 percent of the American people in a recent Gallop poll believe that reducing the demand for drugs through drug education programs is the single most important thing we can do to halt the drug epidemic.

In devising such programs, however, we must never lose sight of the fact that drug prevention begins at home. I have always believed that the way to reduce alcohol and drug abuse is by families working together. Families in America--be they rich or poor, rural or urban, white, black, Asian or Hispanic--all need our help and support.

(MORE)

The drug menace and the scum who perpetrate it, manage to inflict their pain everywhere in our society. Clearly, we need a one-two punch against suppliers as well. Tough laws and tough law enforcement are an essential part of our battle plan.

But, getting tough on drug abuse means more than reconnaissance planes, trained German shepherd dogs, and jail cells. It means denying the pushers their market. It means education, prevention and treatment. We have made much progress in the drug crisis in recent years. Thirty-seven federal agencies are working together in a vigorous national effort. We have increased seizures of illegal drugs, though more importantly, individual use of drugs has dropped. And, we're making some progress in the area of treatment and prevention. But the battle has just begun.

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The **Chairman**. We want to hear from each of our Members. We will ask if they would do it in a timely fashion so we will be able to meet the Reverend's schedule.

I recognize Senator Pell from Rhode Island.

Senator **Pell**. Thank you very much, Mr. Chairman.

I am very glad indeed to be here joining you in welcoming the Reverend Jackson. I am going to have to leave shortly to go back to the Floor on another matter, so I would ask unanimous consent that my statement be inserted in the record as if read.

The **Chairman**. Without objection, so ordered.

OPENING STATEMENT OF SENATOR CLAIBORNE PELL

Senator **Pell**. Good morning, Mr. Chairman, my distinguished colleagues, Ladies and Gentleman.

I am delighted to be here this morning to hear the testimony of people who truly know what is going on in the communities of our nation when we talk about drugs. And talk we do—every newspaper, magazine, television and radio broadcast—tells us abut the tragedy of drugs. About how drugs are hurting our young people, about how drugs are increasing the crime rate, about the personal and societal toll this epidemic has created throughout this nation.

While much recent attention has been focused on, and indeed must address the national impact of drugs, including the effect of drug importation and the increased need for border control, the human toll this crisis exacts does not wait for Congressional recommendations or legislation. Every day, people who care in communities throughout this nation work with those for whom Congressional action may be too late—the young kids who are urged to try drugs by their classmates, the teenagers who get hooked and frightened, the adults too drugged to care.

We have with us today leaders in the field of drug prevention, education, and treatment. Many of these witnesses were fighting drugs and drug abuse long before the issue pervaded the public consciousness. And it is their expertise and experience that we seek as we make critical judgments about how to stop this tragedy which grip our nation.

I am pleased to welcome—among these excellent witnesses—the Reverend Jesse Jackson, who has been so prominent in bringing the issue of drug abuse to national attention and, indeed, to the 1988 Presidential campaign.

I am also delighted to welcome here today a fellow Rhode Islander, Mr. David Mactas, President of Marathon House of Providence, R.I. As Mr. Mactas will describe, Marathon House, a residential treatment facility, began 21 years ago in Providence, and has now expanded to 7 other locations in Massachusetts, New Hampshire, and Vermont.

Marathon House and its dedicated staff currently provide daily inpatient services to 128 individuals in four New England states. By the fall, when two new adolescent treatment centers open, Marathon House hopes to provide inpatient services to some 170 individuals. In addition, Marathon House is now able to provide needed treatment, counseling, and assistance on an outpatient basis to some 65 individuals throughout New England and hopes to increase that number as its additional centers open.

While Marathon House's success rate in treating substance abuse is impressive, the number of people it is able to help is not. As Mr. Mactas will describe, the need is great, and we in Congress must know that Rhode Island, unique in so many ways, is all too usual in its need for expanded services.

I am delighted that Mr. Mactas, who has recently been appointed to serve on the Drug Abuse Coverage Study Committee of the National Academy of Sciences' Institute of Medicine, and who has just completed a four year tenure as President of the Therapeutic Communities of America, was able to join us here today to give us the benefit of his experience.

In addition to increased need for access to treatment, there is tremendous need for access to effective educational programs in our schools. I recently had the opportunity to visit the Tiogue Elementary School in Coventry, Rhode Island. This school is, I believe, the only school in New England to have been recognized by the Secretary of Education as a "Drug Free School." The Tiogue School program underscores the central role that schools can and must play in drug abuse prevention and education. We recently reauthorized the Drug Free Schools Program as part of our omnibus elementary and secondary education program. The $250 million authorized for Drug Free Schools is a critical investment in the future welfare of our country, for it will serve to prevent untold personal and societal costs which result from drug addiction, many of which we will undoubtedly hear about this morning.

I would like to take this opportunity to thank all the witnesses present today, and look forward to their excellent, informative testimony.

The CHAIRMAN. You may proceed.

Senator PELL. Thank you.

I want to emphasize the importance of this day's hearing and congratulate the Chairman on calling it. The problem with drugs and drug addiction in our Nation is a growing problem; we are losing the battle. And I think that hearings like this and legislation which we hope emerges from these hearings will help us do victorious battle against the drug problem.

I would also add that David Mactas from my State of Rhode Island will be testifying. He has had great experience in this field. I only regret that I cannot be here when he testifies, because I have to be giving another speech myself at the Library of Congress. But I am very glad he is here.

And finally, I would like to add a personal welcome to Reverend Jackson, because I have long admired him, and we even walked in a march together. So I welcome him.

Reverend JACKSON. Thank you, Senator.

The CHAIRMAN. Senator Stafford.

OPENING STATEMENT OF SENATOR STAFFORD

Senator STAFFORD. Thank you, Mr. Chairman.

Mr. Chairman, I am pleased to join you today at the Full Committee's timely hearing on the issue of drug abuse in this country. I am particularly pleased that the word "education" is in the title of this hearing. Of all the ways of dealing with our country's pressing drug problem, in the opinion of this Senator, education holds the greatest promise of stemming the tide of drug abuse.

In the recent reauthorization of the Elementary and Secondary Programs, the Drug-Free Schools and Communities Act was refined, and $250 million was authorized to further the implementation of promising programs in elementary and secondary schools around this Nation.

According to figures compiled by the Office of Management and Budget, the Federal Government will spend over $450 million this year on drug abuse prevention. This amount pales when compared to the costs inflicted on individuals and society through the use of illegal drugs. The stakes are high. This is a war we cannot afford to lose. In the mind of this Senator, the best way to prevent drug and alcohol abuse is through education.

Programs instructing our children of the dangers of drug use have proven effective. A recent national survey of high school seniors confirmed that the number of students claiming to be users of cocaine has declined. That same survey reported an increase in the perception among students that cocaine is a dangerous drug and can be harmful with just one use. Even with these encouraging results, it is clear that we must intensify our efforts to educate young people about the dangers of drug and alcohol use and abuse.

We cannot afford to lose one more young mind to drugs or alcohol. The lives and talents lost to drug abuse cannot be recovered. Today's children live in a world far different from the one I recall in my own childhood. Drugs are readily available to children of all ages in neighborhoods at every socioeconomic level.

As a Nation, we have the capability and the resources to educate young children about the devastation drug use inflicts on the mind and the body. We cannot afford to fail at this task. There is much work to be done in our homes, our schools and our communities. America will not be a truly drug-free society until every child and every adult understands why drugs should be avoided. Sound education programs are a vital tool for achieving this goal. Education offers the best opportunity this Nation has for creating a safer, healthier, drug-free world.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Simon.

OPENING STATEMENT OF SENATOR SIMON

Senator SIMON. Thank you, Mr. Chairman.

I have seen our witness before somewhere—I cannot recall where. [Laughter.]

And I knew that Jesse Jackson was a man with great persuasive abilities, but I did not expect to see Orrin Hatch wearing a Jesse Jackson button here, I have to confess. [Laughter.]

More seriously, I want to commend our first witness. Jesse Jackson's war on drugs has not been an election year war. He has been there fighting this for years, and has done a remarkable service to this Nation.

In terms of what we ought to be doing, I think we know some of the things we ought to be doing. We know that there is a wait of weeks and sometimes months to get into treatment centers. And when you can't get into treatment centers, you continue your habit. We know that education works. Senator Stafford just talked about it.

We have seen what has happened with cigarette smoking. We can do a much more effective job on drugs than we have done. And finally, I think we should also remind ourselves that we can't disassociate the problem of drugs from other social problems. This problem of drugs is directly tied into this preschool education problem that we had a hearing on just the other day. When you have intensified preschool education, you change the dropout rate.

You show me an area with a high dropout rate, and I'll show you an area that has a high drug use rate and a high alcoholism rate. You show me an area that has a high unemployment rate—I'll show you an area that has a high drug rate and a high alcoholism rate.

So that we cannot just deal with the drug problem in isolation and think we are going to solve it without looking at the attendant social problems that face our society.

But again, Mr. Chairman, I am pleased you are having these hearings, and I am very pleased that we have, appropriately, as our first witness a distinguished American, Reverend Jesse Jackson.

The CHAIRMAN. Thank you very much.

[The prepared statement of Senator Simon follows:]

Paul Simon

STATEMENT OF SENATOR PAUL SIMON
HEARING ON PREVENTION AND TREATMENT OF DRUG ABUSE
COMMITTEE ON LABOR AND HUMAN RESOURCES
JUNE 16, 1988

Mr. Chairman: I join you in welcoming these witnesses to a hearing on one of the most critical issues facing us today as a nation -- the question of how we are going to end the serious problem of drug abuse in this country.

We have a tendency, when dealing with national issues, to address and then ignore; to legislate and forget; to pretend that we have corrected an error, when in fact we have not. Despite our best intentions, we sometimes fail in our policies. This is the case with the "war on drugs".

More than a year ago President Reagan stood in the West Hall of the White House to tell the people of the United States that "we have made much progress" in our fight against drugs. He told us that there were shortages of marijuana, that use among high school seniors was down and that seizures of illegal drugs were up.

It has been more than a year since Congress said "no" to drugs by passing the the single, largest anti-drug abuse effort in the history of the nation.

In six years of fighting drug abuse, the Reagan Administration spent more than $11 billion on its war on drugs. In an effort to reduce the supply of narcotics and illicit drugs, 75 percent --$8.6 billion -- has been spent on law enforcement and interdiction efforts. Twenty five percent ($2.6 billion) has been spent on prevention and treatment, or demand reduction.

Despite President Reagan's comments, marijuana remains the most commonly used illicit drug in the nation. Estimates are that as many as ten percent of our nation's teens currently smoke marijuana on a regular basis; as many as 20 million Americans may be regular users.

Fortunately heroin use is down, but there are still 2 1/2 million addicts. And for every ex-heroin and PCP user, there is a new addict. The number of deaths and illnesses related to cocaine and crack has tripled during the last six years . There may be as many as 6 million regular users of cocaine in the United States.

The faces of the victims are familiar to us all. And the costs that we bear are incredible.

The community pays the price of drug abuse in alleys and in classrooms. It pays in the fear to walk through streets, the failure to graduate students. And it responds by hiring more police to fight crime and building jails to house criminals.

The economic and social costs of substance abuse are immense. Most recent estimates place the cost of substance abuse at $276 billion per year. No one knows that figure precisely, but we know it is unbelievably high.

The Reagan Administration has largely ignored the people who are victims of substance abuse. Its supply-oriented drug policy is only part of the picture, like its supply-sided economy. In an effort to reduce the drug supply, we have mobilized the Coast Guard, squadrons of airplane patrols, special drug divisions of state and local police departments, customs inspectors psychologically trained to detect smugglers and a special task force headed by the Vice President. We have burned and reburned fields of marijuana in Mexico and cocaine in Columbia. We have pointed the finger outside our borders.

We have failed to get to the other side of the problem. We have failed to accept responsibility. We are failing to prevent. We are failing to provide treatment. We are losing the war.

If there is no effective constraint on the demand for either drugs or alcohol, the supply will continue. Illegal profits and demand will continue to stimulate human ingenuity to deliver drugs over, under and through whatever barricades we erect.

It is the drug user who keeps the market going. We must reach that user, in addition to stopping the traffic itself. We must reduce the demand.

That challenge is the more difficult one. Prevent. Prevent the experimentation with drugs. Prevent the peer pressure. Prevent chronic use. Prevent the need to depend on a chemical for hope.

The single most important tool for prevention is education. But we know through our experience with nicotine that being aware of the dangers of a drug or chemical is not always enough to change behavior. We must educate about the dangers of drugs, but we must also educate about the joys of life. We must identify the social and emotional circumstances that contribute to substance dependency. And we must provide support and skills for coping with those problems.

It is a tough world for the children of the 80's. It is tough because the family has changed. It is tough because the time seems shorter. It is tougher to compete, to succeed and it is a frightening world. Talk to a group of fourth graders, and one of the questions that overwhelms you is about nuclear war. As a child, I remember thinking about what I wanted to be when I grew up, not whether I would grow up.

We must give the American family the support it needs. It should not surprise us that in an era of single parents, latchkey children, television violence, youth unemployment, teen suicide and teenage pregnancy that America's children are turning to drugs. The world is complex. Simplistic slogans will not significantly reduce our problem.

Infusion of federal funds to fight drugs must be localized and we must direct our efforts toward primary prevention. We can broadly define on the federal level what needs to be done, and we can target resources. Clearly we need to redouble our efforts in the area of research. But drug and alcohol education, prevention and treatment must be in response to the needs of the community. Communities differ. The attack must be on reducing demand and our budgetary priorities must reflect that. If we do not want our children on the streets, then we must offer them alternatives.

Drugs and alcohol are often the refuge of those who have give up hope or for those who do not feel a part of society. No single step we can take would erase more drug use than giving every jobless American the opportunity of a job.

Adequate funding for schools supporting extracurricular activities is another essential if our children are to have those opportunities. We should be encouraging student involvement in establishing comprehensive drug education and prevention programs. We should be training educators to identify high risk students and to intervene. We should be working more with parents to encourage their involvement as well.

We need to educate, inform and offer hope. We need a full partnership of parents, educators, the private sector, the public sector.

We must help give the communities of this country the resources necessary to prevent and treat drug abuse. We must help them on the front line as they seek funding for their overcrowded schools and treatment centers.

We must give the employers of this nation the incentive to provide counseling, not testing; health care not unemployment.

We must give our schools the teachers and resources to do the job the way they know they must do the job.

If we value lives and recognize we cannot afford to continue to lose their contribution to this nation, we will take these steps, and we can win the war on drugs.

The CHAIRMAN. Senator Weicker.

OPENING STATEMENT OF SENATOR WEICKER

Senator WEICKER. Mr. Chairman, thank you very much, and especially thank you for holding the hearings.

Jesse, the significance of Senator Hatch wearing this button is not lost to me; it signifies some sort of a philosophical conversion.

Senator HATCH. Don't count on it too much.

Senator WEICKER. If that is the case, then I welcome it, because it means that he can join me in the corner that has been reserved for me at the Republican Convention in New Orleans. [Laughter.]

Senator HATCH. I don't think I will ever be that bad; I want you to know that.

Senator WEICKER. Mr. Chairman, it is a great pleasure to be a part of the hearings. I will ask unanimous consent that my full statement be included in the record.

The CHAIRMAN. Without objection.

Senator WEICKER. The comment that I do want to make is that we have had major action on the Floor of the Senate in the past month on the war on drugs—major action really having, in my opinion at least, not much impact on the job that needs to be done. We have passed capital punishment bills; we have talked about "drug czars"; we have called out the armed services—all of which sound very, very tough. Then on the other side, we hear what needs to be done in terms of this Committee—early education, funding the law enforcement agencies that have the responsibility and the expertise to face up to the problem—and we talk about drug addiction programs that, as Senator Simon has mentioned, have waiting lists of six months in my own home State of Connecticut.

But, what it all comes down to is that the only bullet that the Senate can manufacture in the war on drugs is money, and that, we are not doing, because everybody has been out there, making promises about how we are not going to raise revenue. I don't know how we can face the new problems and the new opportunities with yesterday's budget.

If we are going to have a war on drugs, then we had better start voting the money to wage the war—not reprogramming mental health and drug abuse funds; not cutting the Coast Guard; but raising the revenue to finance early education, law enforcement, Coast Guard, et cetera, and drug addiction programs. The Nation will know that the war has begun when at least 51 Senators stand up in their places down there and vote to raise the money to wage the war.

[The prepared statement of Senator Weicker follows:]

OPENING STATEMENT OF SENATOR LOWELL P. WEICKER, JR.
DRUG ABUSE PREVENTION, EDUCATION, TREATMENT HEARING
JUNE 16, 1988

TODAY WE ARE HERE TO HOLD AN IMPORTANT HEARING TO EXAMINE WHERE WE ARE AND WHAT WE MUST DO TO WIN THE WAR ON DRUGS. YES, EVERYONE HAS BEEN WILLING TO DECLARE A WAR ON DRUGS, BUT WE HAVE NOT YET FULLY CONSIDERED WHAT MUST BE DONE IN THE AREA OF PREVENTION, EDUCATION, AND TREATMENT--AND I'M GLAD TO SEE THAT THESE ISSUES ARE THE FOCUS OF TODAY'S HEARING. WHILE DRUG ARRESTS, DRUG SEIZURES AND PRISON SENTENCES FOR DRUG DEALERS ARE ALL UP, AT THE SAME TIME, EXISTING TREATMENT PROGRAMS ARE OVERWHELMED BY THE DEMAND FOR SERVICES, AND ASKING OUR YOUTH TO "JUST SAY NO" TO DRUGS IS SIMPLY NOT ENOUGH.

CLEARLY, OUR CURRENT EFFORTS FALL FAR SHORT OF WHAT IS NEEDED TO COMBAT THE SPREAD OF DRUG USE. MORE THAN 23 MILION AMERICANS USE DRUGS AT LEAST MONTHLY, INCLUDING MORE THAN 6 MILLION WHO USE COCAINE. HALF OF ALL HIGH SCHOOL SENIORS HAVE USED ILLEGAL DRUGS AT LEAST ONCE, AND OVER 25 PERCENT USE DRUGS AT LEAST MONTHLY. DRUG USE IS NOT LIMITED TO ANY ONE SEGMENT OF OUR SOCIETY. IT IS NEITHER A WHITE COLLAR OR BLUE COLLAR CRIME, NOR IS IT LIMITED TO PARTICULAR AGE OR ETHNIC GROUPS. IT AFFECTS ALL OF US.

AND THE COSTS OF OUR FAILURE IN THE WAR ON DRUGS IS MASSIVE: 10 TO 15 PERCENT OF ALL HIGHWAY FATALITIES INVOLVE DRUG USE; DRUG

USERS ARE 3 TIMES AS LIKELY TO BE INVOLVED IN ON-THE-JOB ACCIDENTS, ARE ABSENT FROM WORK TWICE AS OFTEN, AND INCUR 3 TIMES THE AVERAGE LEVEL OF SICKNESS COSTS AS NON-USERS. AND WHEN IT COMES TO DRUG-RELATED CRIME, IT IS NOT ONLY THE DRUG SELLERS AND BUYERS WHO ARE AT RISK, BUT INNOCENT BYSTANDERS WHO BECOME THE VICTIMS OF OTHERS' CRIMINAL BEHAVIOR.

FINALLY, THE ROLE OF INTRAVENOUS DRUG USE IN THE SPREAD OF AIDS IS WELL DOCUMENTED. I.V. DRUG USERS MAKE UP APPROXIMATELY 25 PERCENT OF ALL AIDS CASES IN THE NATION. THESE DRUG ABUSERS ARE A SOURCE OF INFECTION NOT ONLY FOR OTHER I.V. DRUG USERS WITH WHOM THEY SHARE NEEDLES, BUT ALSO TO THEIR SEXUAL PARTNERS AND TO THEIR UNBORN CHILDREN. IN FACT, 65 PERCENT OF ALL AIDS CASES AMONG THE HETEROSEXUAL POPULATION CAN BE ATTRIBUTED TO SEXUAL CONTACT WITH AN IV DRUG USER. SEVENTY PERCENT OF CHILDREN WITH AIDS ARE BORN TO IV DRUG USERS OR TO WOMEN WHO ARE SEXUAL PARTNERS OF IV DRUG USERS.

CLEARLY, SOMETHING MUST BE DONE IMMEDIATELY TO ADDRESS THIS SERIOUS THREAT TO OUR NATIONAL SECURITY AND TO THE VERY FABRIC OF OUR SOCIETY. IF I MAY BORROW A QUOTE FROM OUR FIRST WITNESS, THE REVEREND JESSE JACKSON, "DEMOCRACIES ARE TEETERING ALL OVER THE WORLD BECAUSE OF DRUGS. OUR CHILDREN AND CITIES ARE BEING INVADED BY DRUGS. AND OUR FOREIGN POLICY IS UNDERMINED BY DRUG DEALING BY FRIEND AND FOE ALIKE. IT'S NOT ENOUGH TO JUST SAY NO. IT'S TIME TO SAY YES--TO ACTION."

I COMMEND THE CHAIRMAN OF THIS COMMITTEE FOR CALLING THIS HEARING TODAY AS IT BRINGS NATIONAL ATTENTION TO THE NEED FOR A COMPREHENSIVE, WELL-COORDINATED EFFORT IN DRUG ABUSE TREATMENT AND PREVENTION. I AM ALSO PARTICULARLY PLEASED THAT CURRENT EFFORTS TO DRAFT AN OMNIBUS DRUG BILL IN THE SENATE ARE EMPHASIZING TREATMENT AND EDUCATION. WE NEED TO INVEST DOLLARS IN DRUG ABUSE PROGRAMS TO TEACH OUR CHILDREN AT AN EARLY AGE THAT USING DRUGS LEADS NOWHERE, IF NOT TO AN EARLY GRAVE. AND WE NEED TO INVEST FUNDS IN TREATMENT PROGRAMS. IF WE DON'T INVEST DOLLARS TO STEM THE DEMAND FOR DRUGS, EFFORTS AT INTERDICTION AND ERADICATION WILL BE FUTILE--THE DESPERATE DRUG USER WILL SOMEHOW FIND A SUPPLY.

THIS ADMINISTRATION, DESPITE ITS CLAIMS THAT DRUG ABUSE IS ITS NUMBER ONE DOMESTIC PRIORITY, HAS A DISAPPOINTING TRACK RECORD WHEN IT COMES TO REQUESTING FUNDS FOR TREATMENT AND EDUCATION PROGRAMS. IN FACT, IT HAS CONSISTENTLY FALLEN TO THIS CONGRESS TO REJECT ADMINISTRATION PROPOSALS TO CUT DRUG PROGRAMS. IN THE PAST, WE HAVE BEEN ABLE TO RESTORE SOME FUNDS TO THESE PROGRAMS, BUT MORE IS NEEDED. WE HEAR OF LONG WAITING LISTS AT EXISTING TREATMENT CENTERS AND OF YOUNG CHILDREN EXPERIMENTING WITH BOTH DRUGS AND ALCOHOL. AT THE SAME TIME, WE HEAR OF SUCCESSFUL EDUCATIONAL PROGRAMS BEGINNING IN KINDERGARTEN, AND OF METHADONE TREATMENT CENTERS WHICH ARE WORKING.

AND I'D LIKE TO MAKE ONE MORE POINT WHEN IT COMES TO THE FUNDING OF THIS WAR ON DRUGS. WE CANNOT WIN WITHOUT A SUBSTANTIAL INVESTMENT OF FEDERAL DOLLARS FOR PREVENTION, EDUCATION AND

TREATMENT. YET, THE DOLLARS SIMPLY DON'T EXIST IN THE LABOR-HHS-EDUCATION APPROPRIATIONS BILL TO DO THE JOB. AND, WITH AN ALLOCATION FOR OUR SUBCOMMITTEE THAT FALLS BELOW THE PRESIDENT'S REQUEST FOR THE PROGRAMS UNDER OUR JURISDICTION, WE WILL HAVE TO STRUGGLE TO FUND OUR EXISTING PRIORITIES--MUCH LESS FUND A MASSIVE NEW COMMITMENT TO FIGHT DRUGS. IT WILL HAVE TO COME FROM SOMEWHERE--BUT NOT FROM AIDS, NOT FROM SPECIAL EDUCATION AND NOT FROM LOW-INCOME ENERGY ASSISTANCE. IF IT REQUIRES REORDERING OTHER PRIORITIES, OR RAISING REVENUES, SO BE IT.

I WELCOME THE WITNESSES HERE TODAY WHO CAN SHARE WITH US THEIR EXPERTISE AND EXPERIENCES IN TREATMENT, EDUCATION, AND PREVENTION IN AN ERA OF SCARCE RESOURCES. WITH THEIR HELP, I HOPE THAT WE MAY BE ABLE TO BEGIN THE UPHILL BATTLE TO WIN THE WAR ON DRUGS.

The CHAIRMAN. Senator Harkin, do you want to follow that one?

OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. It is hard to follow Senator Weicker—but I have followed him before, and I am not embarrassed to follow Senator Weicker.

Mr. Chairman, I want to thank you also for holding this hearing. We are especially honored to have with us today Reverend Jackson who, as Senator Simon said, has made the war on drugs not just a part of his candidacy, but indeed, part of his adult life. And for that, we are all entirely grateful.

I know today we are going to hear repeated time and time again how drugs are affecting our schools and our communities. I am looking forward to hearing especially the thoughts and solutions that you, Reverend Jackson, would bring to us.

But I want to add just one note. I think it is important that, while much of our attention has been focused on illicit drugs, also we focus our attention on the use of licit drugs in our society. And I am talking primarily about alcohol—the most widely used drug in America today. It is the most lethal, deadly drug in our society, and kills more people than any illegal drug, imported or domestic. And yet no one talks about it. It is glamorized, it is advertised, it is subsidized, and the Government taxes it.

If anyone in this room were to go to a reception on the Hill this evening—and there will be hundreds of them around the Hill—and you were to walk in the door and someone were to hand you a glass of water and two downers, you'd run out of there as fast as you could. You'd probably think you had stepped on another planet. But if you go to that reception this evening, and you walk in the door, and someone hands you a glass of whiskey or a vodka or a gin and tonic, that's perfectly acceptable. But they both have the same effect—they both have the same effect.

And look at the carnage that is happening out in America today because of alcohol. There is a carnage because of the use of cocaine and heroin and other drugs—but look what's happening just because of the use of alcohol—but no one wants to touch that. No one wants to even talk about it. Well, it has to be talked about, because as I talk to a lot of young people, what I sense them thinking is "You're being a hypocrite. You all go out and drink—get drunked up—but the kind of drugs we're taking have no more serious effect."

How many people, they ask me, were killed last year because they smoked marijuana on our highways? And how many people were killed because of some drunk driver going down the road, loaded up with alcohol?

So I think as we continue this battle on drugs in America, we had better focus on the most widely-used drug of all and the most deadly drug of all, and that is alcohol.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The Senator from South Carolina, Senator Thurmond.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Thank you very much, Mr. Chairman.

Mr. Chairman, I wish to commend you for conducting this hearing on drug abuse prevention, education and treatment. It is most important that Congress direct its attention to the threat posed by drugs, which permeates all levels of society in the United States.

It is clear that our Nation is engaged in a war on drugs. If we are to achieve victory over this insidious enemy, many complex issues must be addressed.

I am pleased that our Committee will have the benefit of receiving testimony today from witnesses concerning the prevention, education and treatment aspects of substance abuse.

There has been increased awareness of the dangers of substance abuse in recent years, which has resulted in substantial increases in funding and the development of resources in these areas. Also, there has been a renewed commitment on the part of law enforcement to step up interdiction to combat the supply of drugs flowing through our borders and waterfronts.

Despite diligent efforts on these various fronts, studies reveal alarming facts about the increased abuse of drugs in the United States. For example, the Heritage Foundation is quoted as saying that it is estimated that one of every ten Americans going to work today has impaired productivity due to substance abuse. The price of this lost productivity in the workplace is costly, equating to as much as $100 billion annually.

Mr. Chairman, much attention has been focused on the use of illegal drugs, like cocaine and crack. The media reports daily on the tragic toll that these drugs are taking on Americans, especially our youth. However, recent statistics show that there is a substance that is abused to an even greater extent than illegal drugs—the one just referred to by my good friend, Senator Harkin—and that is alcohol.

Alcoholism and alcohol abuse are recognized as one of our Nation's most serious problems. A 1987 Department of Health and Human Services report to Congress entitled, "Alcohol and Health", cites that nearly one-half of all accidental deaths, suicides and homicides are alcohol-related. Also, nearly half of our country's convicted jail inmates were under the influence of alcohol when they committed their crimes.

Additionally, alcohol-related traffic accidents claim over 18,000 lives each year in the United States.

Among teenagers, alcohol abuse has reached epidemic proportions. The Department of Health and Human Services estimates that 30 percent, or 4.6 million adolescents, experience negative consequences of alcohol use, such as poor school performance, trouble with parents, or trouble with the law. According to recent statistics, alcohol remains the most widely used drug among America's youth.

Mr. Chairman, for many years, I have firmly believed that addressing the problem of substance abuse should be a priority for Congress. I have introduced legislation to place health warning labels on alcoholic beverages, and this bill has received bipartisan support. I was pleased to receive the endorsement of the National

Rainbow Coalition for my bill, and am most appreciative of the support of Reverend Jesse Jackson, who is appearing as the lead witness before the Committee this morning.

As a fellow South Carolinian, it gives me great pleasure to welcome Reverend Jackson to this hearing. I am confident that his testimony will provide the Committee with insight into the substance abuse problem in America.

And I might say that several years ago, Reverend Jackson was here in Washington, speaking in some of the schools. I was so impressed with what I read in the newspapers about what he had to say, that I clipped it out and sent it to him, congratulating him; I was very proud of the position he took and proud of what he has said on this subject.

Mr. Chairman, as we hear from Reverend Jackson and the other witnesses today, I will be particularly interested in their views about addressing the substance abuse crisis. While my schedule will not permit me to stay for the entire hearing, I look forward to reviewing the testimony that is presented with great interest.

I am a member of the Conference Committee on the Senate Armed Services Committee, and the Strategic Subcommittee is meeting today to reconcile differences between the House and the Senate, and I will have to be there. However, I will certainly read this testimony.

Again, Reverend Jackson, we welcome you to the Senate. We are glad to have you here.

Thank you, Mr. Chairman.

The CHAIRMAN. Reverend Jackson, you have been welcomed. We look forward to your testimony.

STATEMENT OF REV. JESSE JACKSON

Reverend JACKSON. Mr. Chairman, Members of this distinguished Committee, I am delighted to have this opportunity to testify before you today. This is a special day, because of the focus that I have been putting on substance abuse.

Before I came today, I looked at my astrological chart, and I saw something special flying across the stars—it was Hatch supporting Jesse Jackson at the Democratic Convention.

So thank you very much, Senator Hatch, for the conversion.

Senator HATCH. You are welcome, Jesse. [Laughter.]

Reverend JACKSON. I am glad to have the opportunity to be here today to discuss the greatest single threat to our Nation's families—drugs.

Recently, I visited a children's hospital where I saw the small, frail bodies of newborn bodies shaking uncontrollably because they were born drug addicts. These babies had made no decision; they had been given no choice; yet they began their lives living in the agony that grips so many—the agony of an unprevented, untreated, and still profoundly unaddressed drug crisis.

Drugs destroy healthy bodies and communities. Drugs end education and careers. Drugs destroy trust and family ties. Drugs are the biggest source of crime. Drugs, not sexual contact, have become the chief transmitter of AIDS. Drugs are dream-busters, and community destroyers.

I am particularly glad to be able to talk to you today about education, treatment and prevention. Every week, whether in the midst of a campaign or not, I visit two or three high schools to talk to students about drugs, as Senator Thurmond indicated earlier today.

No matter where I go in the country, I see the same story. I ask the students if they know someone who has died because of drugs, and no fewer than 20 percent always stand. I ask them, whether in Naperville, Illinois, or Birmingham, Alabama. And then I ask them, if you know someone who is in jail because of drugs—from Sacramento to Baltimore—40 to 50 percent always stand. And then I ask if you know someone who has tried drugs. The thunderous standing of about 90 percent of our children always stand—whether in Utah or in Massachusetts.

Drugs threaten us everywhere. There are now reports of Los Angeles "crack" gangs infiltrating small cities in Iowa.

There has been an attempt to reduce the drug problem to a few athletes and entertainers, an attempt to portray it as the problem of our children and their role models alone. For their own well-being and as role models for our youth, entertainers and athletes have a responsibility not to use drugs. But we cannot fool ourselves into thinking they are the problem. Athletes, entertainers and children are not buying $150 billion worth of illegal drugs a year. They are not laundering that amount of money through our banks. They are not bribing foreign officials and undermining even our Government's credibility around the world. No—adults are responsible for these things.

Indeed, to our collective horror, even the CIA appears to have had a hand in promoting and protecting known drug dealers. Today is not the time to discuss this matter in detail. But no discussion on drugs can avoid the severity of this scandal. Money, arms and drugs have been bound together to form either the most corrupt or the most inept dimension of our foreign policy.

Every day, more skeletons rattle out of the closet of the Reagan/Bush Administration. Congress and the American people must be given a full and complete account of these sordid episodes.

When did Noriega get on our payroll, and what was his job description, and why did he want as much payment as the President of our country? We the people need a committee like this to go to Panama. We need to know both sides, and then the full story. Our character is on trial. Our credibility is at stake.

Indeed, drugs are a corrupting influence on the entire fabric of our society. At least we are beginning to take the threat seriously. Over the past year, drugs have rightly moved to the forefront of the Presidential campaign. Before this, all we heard was the Reagan Administration urging children to "Just Say No". All we saw was Mr. Bush and the Drug Commission just doing nothing, while the Coast Guard budget and drug treatment funding were kid.

During the campaign, I have outlined a comprehensive plan for fighting drugs and a budget to pay for the fight. I have attached a copy of my proposal and ask that it be made part of the record of the hearing.

I am pleased to report that my proposal has been adopted by the Platform Drafting Committee of the Democratic Party. I am sure Senator Hatch will make sure that the Republicans include it as well—my ally in the struggle.

We must reduce the supply of drugs at the source by engaging in economic development and crop diversification programs in countries that grow drugs. We must increase funding and resources for drug interdiction at our borders. We must appoint a national "drug czar" to mobilize and oversee a comprehensive, government-wide program. We must address and we must increase assistance to local law enforcement officials to fight drugs.

Much attention has been appropriately devoted to the most effective role for the military to play in the fight against drugs. We must be careful, however, to avoid involving the military in any police actions against citizens or arrests. The primary line of defense against smuggling should remain a strengthened Coast Guard and Customs Border Patrol.

International drug policies must be coordinated by the national "drug czar", with the full participation of the State Department. We should not lead with our military forces in drugs in any other aspect of foreign policy. But the military can play a greater and useful role in backing up these efforts and providing intelligence assistance. Drugs are very literally the number one threat to our national security and to the lives of our young people. Every, single agency of Government that can help must be mobilized.

In addition to reducing supply, we must take comprehensive steps toward reducing demand for drugs. The steps we need to take are not mysterious. We must provide treatment on demand. It is truly insane to have waiting lines for treatment programs, when the costs to society of continuing drug use are so high. The average heroin addict in New York City steals upwards of $30,000 a year. Yet, when that addict wants treatment, he or she may have to wait six weeks to 18 months.

Police crackdowns and clean sweep operations can, at considerable expense, break up drug markets for a short time, and during that time, hundreds of addicts may seek help. If there are only dozens of beds, the opportunity has been lost.

I have been to successful drug treatment centers from Eugene, Oregon to Miami, Florida. We know how to help those who want it. What we need is adequate funding.

The President's AIDS Commission has called for treatment on demand. We are wasting lives when we wait to meet their call. We need a comprehensive drug education program, beginning at the earliest ages. We must educate all of our children about the dangers of drug and alcohol abuse.

The Secretary of Education should develop drug education strategies and materials. We must wage an aggressive nationwide campaign, led by an actively-involved President, to educate people about the dangers of drug abuse, particularly given the present threat of AIDS.

Early education has a particularly important role. Children who have received adequate support from the very early stages of life, from early years nutrition to preschool education, are less likely to fall into drug dependency.

Our battle against drugs is complex and multifaceted. The earliest prevention is the best approach. The war on drugs is not free. The plans I discussed above would cost an additional $3 billion per year, though they would save far more in reduced health, crime and other costs. This amounts to a penny out of every defense dollar. It is an investment we can afford.

While we must approach the problem as we would a war plan, with strategies and plans, with weapons and soldiers, we must never lose sight of the moral foundations of the problem. Some people try drugs as a way of getting temporary excitement. Others try drugs because of peer pressure. Some get hooked out of despair and a loss of hope. Still others seek to escape reality and the future, using drugs as the anesthesia for their pain. Many stay on drugs because they are physically addicted.

But regardless of the reason for being on drugs, every person can get off drugs by using all of the resources at his or her disposal, including medical power, mind power, moral power and will power.

Drug pushers are terrorists. We must fight them without surrender. Up with hope, down with dope, is a message we must take to our communities and families. Our Nation's security depends upon it. The struggle to fight a war on drugs begins with leaders taking very seriously a commitment to end the drugs.

I say this lastly, my friends. I stayed in Watts in a home with people a few weeks ago where there is a profound crisis of drug flow and the killing of people. I stayed with a young woman who has three children. If she goes to work, there is no day care for her children, and she will be called an unfit mother. If she stays home with those children and does not work, she will be called a lazy mother. That mother and those children need a way out.

And then I met with the gang leaders themselves and told them to their faces that their pushing drugs was immoral, it was wrong, and they were terrorists and must be dealt with straight up.

They did not put forth an argument; they literally surrendered. They said, well, you are wrong. But the fact is we do not have jobs; JEPTA has displaced CETA, it has not replaced it. And then they said, "We do sell drugs down here, but we don't grow them. We pick them up at the port. If we can pick them up at the port, so can law officials. And we launder them with the bankers. If we can, the law can catch them."

Then they said, "We use Uzis and AK747s—the latest NATO weapons. We buy them across the counter on Long Beach Boulevard, and sometimes we rent them." And no one stops it from drug pickup, and no one stops them from buying these latest weapons across the counter.

And so, my friends, let's bust the drug pushers. But bust the gun sellers, and bust the bankers who launder the money, and bust the Government officials who bring down the credibility of our Government.

Thank you very much.

[The prepared statement of Reverend Jackson follows:]

Jesse
Jackson
'88

◆ Issue Brief ◆

Confronting the Drug Crisis: Jesse Jackson's Anti-drug Program

> *The drug crisis is the number one threat to our national security. Democracies are teetering all over the world because of drugs. Our children and cities are being invaded by drugs. And our foreign policy is undermined by drug dealing by friend and foe alike. It's not enough to just say NO. It's time to say YES—to action.*
>
> ***—Jesse Jackson***

Cut Off Drugs at the Source

The stability of many of our allies is severely threatened because of drugs. We may already have lost the government of Columbia to bribes, threats and murders by the drug traffickers. Extraordinary measures are needed to break this international drug cartel which is making drug dealers more powerful than governments.

We must:

- *Make Stopping Narcotics Production and Trafficking Our Number One Foreign Policy Priority with Drug-Producing Countries.*

Secretary of State George Schultz never publicly discusses the international drug problem - yet it is the most serious national security problem faced by our nation. We must persuade and assist drug-producing countries to implement a massive, comprehensive multi-faceted program to stop drugs at the source. If they agree do so, the U.S. should substantially increase its programs of drug-enforcement training, equipment and material assistance, as well as aid for economic development and crop diversification. If they do not commit to such an effort, we must enact substantial trade and diplomatic penalties.

- *Hold a Western Hemispheric Summit on Drugs.*

Action in the United Nations and the Organization of American States is needed to determine the best course of action required to protect our sister democracies from going under. In countries like Columbia, international troops may be needed to deal with the crisis.

- *Give Life to the Mexico-United States Commission on Narcotics.*

Mexico is the source of more than one-third of our drug traffic. We need a strategic plan, developed in concert with the Mexican government, to restore the effectiveness of Mexico's marijuana and opium eradication programs and to control the flow of drugs over the border into the U.S.

- *Stop Banks from Laundering Drug Money.*

Drug dealers are able to take their profits from our pain and launder them through banks around the world. We need to negotiate international banking agreements in order to freeze and seize the assets of drug pushers and put an end to their enterprises.

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Jesse Jackson: Confronting the Drug Crisis

Secure Our Borders

We must:

- *Increase Drug Interdiction Forces.*

We are being overwhelmed at our borders by the invasion of drugs. It does not make sense to have 325,000 troops stationed in a Europe at peace, while, at home, we have a Coast Guard and a Customs Service incapable of protecting our citizens in the war against drugs. We need to increase interdiction spending by 50 percent over proposed 1989 levels.

- *Establish a National "Drug Czar."*

Federal drug-related activities are now fragmented among at least 17 major agencies. A "Drug Czar" is needed to coordinate all of these efforts, someone with the authority and the funds to implement a comprehensive plan of attack.

Bust the Dealers

State and local law enforcement officials have become gridlocked with the number of narcotics prosecutions and by violent and petty crime related to drug trafficking and abuse. Drug dealers know their chances of getting caught, or if caught, of being prosecuted, are slim, because the courts are so clogged. A recent Justice Department study found that nearly three-quarters of all men who were caught committing crimes in 12 major urban areas tested positive for drugs. Yet President Reagan's 1989 budget proposes no federal funds to assist in local law enforcement efforts. We must fully fund the $230 million mandated by the Narcotics Control Assistance Act and double that amount to aid local law enforcement.

Provide Treatment on Demand

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Our lack of drug treatment programs means suffering, death, crime, the spread of AIDS, increased health care costs, loss of productivity, and much more. About 50 percent of drug abusers would like to kick their habit; perhaps 50 percent of these people would successfully complete a program if it were available. But now they have almost nowhere to go. The few programs that exist have long waiting lists. When they are turned away, they go back on the streets and back on the drugs. We must support the Presidential AIDS Commission proposal to increase spending on drug treatment programs to $2 billion per year.

Expand Drug Education & Prevention Efforts

We must:

- *Institute a Comprehensive, School-based Effort.*

We must move beyond mere slogans urging us to "say no to drugs." We must put our money and our effort where our mouth is and begin drug education as early as possible. The Secretary of Education must lead the effort to set national standards for drug education and promote curriculum development. Because our best chance to control drug abuse is through education, we must expand funding for education and prevention above the proposed 1989 level of $611 million.

- *Implement an Anti-drug Awareness Campaign.*

From the President on down, we need strong leadership in an anti-drug campaign. If the federal government can embark on a successful public relations campaign to reduce cigarette smoking, we can wage a similar effort against drugs. In conjunction with the private sector, we should develop public service announcements and other anti-drug messages as part of a comprehensive program.

Make the Necessary Financial Commitment

It is time to put up the necessary resources to meet this national security threat head-on. Current federal funding for all drug-related efforts is less than $4 billion—about five days of the Pentagon's budget. We must change priorities. We need Drug Wars far more than Star Wars.

Jesse Jackson's Proposed Anti-drug Budget

	Reagan Proposed 1989	Jackson Proposed	Difference
Law Enforcement & Interdiction			
Justice	$ 1,504	1,964	+31%
Treasury (Customs)	523	784	+50%
Dept. of Transp.(Coast G.)	625	938	+50%
Dept. of Defense	98	98	--
State Department	111	300	+270%
Other	17	17	--
SUBTOTAL	2,878	4,101	+42%
Prevention	611	917	+50%
Treatment	425	1,685*	+396%
TOTAL	$ 3,914	$6,703	+71%

*This represents the federal portion of increasing spending to $2 billion. We propose that 20% of the increased funds over $425 million needed to achieve a spending level of $2 billion come from state and local governments.

The CHAIRMAN. That is very helpful testimony, Reverend Jackson.

Just for the benefit of the Committee, Reverend Jackson can be with us until half-past the hour. We have a number of Senators here, and we will try and follow maybe a three-minute rule so at least everyone has one opportunity to question. And I would ask the Clerk to notify the Senators.

Reverend Jackson, you have been basically out in the schools with Operation PUSH, you have been talking to students, to schoolchildren, have observed their conduct on this issue for 15 years or more. How has it changed since the time you first went in those high schools to what you find now? Has it changed, and how has it changed, and what real lessons should we learn from it?

Reverend JACKSON. The most profound change is more drug use, and more drug abuse. And because the harder drugs, like cocaine and "crack" and heroin have become the new crisis, the crisis of alcoholism has been pushed to the back burner as either socially acceptable or a non-problem. The alcohol use is the base from which it starts. It usually is the first flight from reality. Alcohol abuse usually is the first anesthesia, and then they graduate to higher levels of drug abuse.

The second observation is the children who are now eight, nine and ten years of age who are either selling the drug and/or even using the drug.

When I have asked children for the most part (a) have you talked with your parents about it, the answer is almost always no; but then, when I have asked parents, have you asked your child is your child trying drugs, they have almost never asked their children—perhaps for fear of what the answer may be.

So I say the solution will be at the two extremes. First, parents must communicate with their children about drugs, but also, they themselves must not try the drugs. It is hard for a drunk person to talk somebody else sober. That is on extreme.

The other extreme is they simply must deal with drugs as a dimension of our foreign policy, and cut the flow off at the source.

The CHAIRMAN. Thank you.

Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

Reverend Jackson, a number of people have called for legalization of drugs. What do you think of that proposal?

Reverend JACKSON. That would be a mistake. It would be a surrender. It is the number one threat to our national security. We would not think of legalizing smog just because there is a lot of it. It is dangerous. It is a health hazard. Don't legalize it—clean it up.

And whether the drugs are being used because it has detected a weakness in our morals or our morale or our basic social orientation, whatever it is, we know drugs really represent a killer. And I see it, Senator Hatch, as a war of the opiate. Many forces that could not defeat us in conventional battlefields are now waging a very successful war where we are weakest, at our level of consumption, and they are having a war unlike any alien ideology ever represented to us as a threat.

Senator HATCH. Mr. Chairman, that's all I'll ask.

The CHAIRMAN. Senator Pell.

Senator **Pell**. Thank you very much.

Reverend Jackson, when do you think the most opportune time is to intervene with youngsters? Is it preschool, pre-high school—what age group?

Reverend **Jackson**. Prenatal care. It starts at the very beginning, because more and more children are being born addicts, so prenatal care. And some of the impediments that come out of lack of prenatal care still cripple children and so damage their sense of esteem, that sometimes they use drugs as an equalizer for themselves.

So I say let's invest in prenatal care. In New York, for example, one year prenatal care for a pregnant mother costs less than $900; a low birth weight baby, up to $1,000 per day, sometimes 20 weeks in the hospital. So, prenatal care, Head Start, day care. We must capture our children's loyalty in their formative years. Better that we invest in and feed the baby than to jail the man or jail the woman. It does start at the level of building resistance.

I met up here a few months ago with some youth. They were black and white and Jewish and Hispanic; there were about 60 of them who were in the Summer Youth Program, Senator Kennedy. And I asked them, "If you were at the party of a friend tonight, and that friend came out around 9:30 or 10:00, wearing a sheet and a hood, with some little ropes on the tray, what would you do"?

They said, "We would be insulted."

I asked, "Why? It's just playing. It's your friend. You are at the friend's house."

They said, "Because the sheet and the hood and the little ropes represent antisemitism; it represents racism."

I said, "But they wouldn't be serious. They would just be playing."

"No one should play like that. We would leave."

I said, "I agree."

I said, "Suppose your friend came out around 10:00 with a little cocaine on the tray. What would you do?"

One said, "Well, he shouldn't do that. If he wants to do it, he should do it in his own room, or maybe his private friends."

There was a different answer for almost everybody. There was no universal resolve to drugs as a killer and as immoral.

So we have grown with a sense of resistance to death by the rope, but death by dope, we are vulnerable. And we must see the drug as an even greater threat than the rope ever was, and drug pushers, even if they are our neighbors, are terrorists.

Senator **Pell**. Thank you very much.

The **Chairman**. Senator Stafford.

Senator **Stafford**. Thank you, Mr. Chairman.

Reverend Jackson, I have listed very carefully to what you have said, and my only question at this point would be: Is there a single step more important than the others that you have discussed that you would rate the most important step the Federal Government could take in eradicating drugs from our communities?

Reverend **Jackson**. Well, since the Government cannot effectively and collectively inspire our youth to say no as the moral resistance and the demand side, the first step would be to convene a hemispheric conference—the Government can do that—of those countries where drugs are grown and work on the collective approach.

I met, for example, with Latin American and Caribbean leaders who would like to be a part of a comprehensive sweep. We have the technology with satellites to know where drugs are grown; we can follow them by sea; we can follow them by air. We know where they come in. If we convened that conference, we would probably hear some of our Democratic allies saying, "Well, we are more threatened by drug flow than we are by an alien ideology called Communism. We need you to help buttress our economy so we can have alternative crops to drug crops. We need enough military aid," they would say, "and economic development to be able to supply jobs to people who work in the drug field and enough military aid to protect ourselves from drug lords who have more military power than we have within our own countries."

So if we begin to strengthen those economies, we pick up powerful allies, at the source of where the drugs are grown. I think when we do that, we will then gain the credibility to speak more effectively to our youth.

Senator Stafford. Thank you very much.

Thank you, Mr. Chairman.

The Chairman. Senator Metzenbaum.

Senator Metzenbaum. Mr. Chairman, thank you very much, and I commend you and Reverend Jackson.

I came late, because I had a conflict. I do have some questions, but I think it is only fair that those who came before me be recognized.

The Chairman. Senator Dodd.

Senator Dodd. Thank you, Mr. Chairman, and I would ask unanimous consent that my opening statement be included in the record.

The Chairman. It will be so included.

Senator Dodd. I appreciate your last comment, Reverend Jackson, about the convening of an international conference, because frankly, there has been a lot of concern expressed in Latin America about some of the statements made in this country about the efforts.

In Mexico, while they still have a major problem in terms of production and transit, they spend 25 percent of their military budget on drug interdiction, 60 percent of their justice department budget on drug interdiction; they have lost over 300 agents in that country, who have been assassinated or executed by drug lords. And when they see resolutions or statements being made that they are not doing enough, and that we point a finger of responsibility at them and them almost exclusively, understandably they become rather upset with the attitude in this country that they are not doing enough or not trying hard enough.

The single largest cash crop in California is not corn; it is marijuana. There are drug enforcement or law enforcement officials in every major city in this country. It is hard to pick up [illegible] newspaper and not find out where some policeman or someone else has been involved, on the take, or involved in the drug problem.

So in terms of dealing with the international effort, it is vitally important, I think, and I'd like to have you comment on this, that we understand that if we are going to get cooperation, we have got to understand that we've got a significant demand problem; we've got a production and transit problem in this country—it just doesn't come from overseas. I think to the extent we do that, we are going to get more cooperation.

If we deal with drugs as we have with trade, and blame Japan and blame Western Europe and fail to assess our own problems in this area, then I think we have just the opposite effect of what you have suggested by calling for some sort of a conference where you involve these countries in a very constructive and positive way.

So I would ask you to comment on that general notion. We have had resolutions that fly through the Senate, overwhelming votes, cutting off aid to one country after another because we don't think they are doing enough. And the attitude in these countries is, well, if you don't, then fine, we're not going to be cooperative. At least, that has been the immediate reaction.

Reverend JACKSON. Well, we are psychologically fixated on stopping Communism as an alien ideology. A good American education and good American opportunity is the antidote to the Communist threat, because people who are educated and who like freedom of press and freedom of religion and freedom of movement and free enterprise, they are not likely to go toward Communism. So that is the antidote to that—good education and opportunity.

On the other hand, if 300 Mexican officials had been killed by Communists, we would see Communism as a threat on our borders, and there would be hysteria, and we would be prepared to guard the borders. But killed by drug dealers are hitting our soft underbelly. There is almost no diplomatic or moral resistance to wary by a syrupy enemy. If we were fighting Communism, we would not be paying for the Communist army. We pay the drug lords to kill us—which is a tremendous and deep psychological and political problem.

So any kind of quick fix, "catch 'em, burn 'em up" solution does not address the nature of the crisis.

So as I said in response to Senator Stafford's question, again, the first step—if we convene the heads of state where the drugs are grown and let them share as I am sharing today, they would give us even more revealing testimony and some recommendations. We are trapped with our children and our officials taking the drugs. Their whole democracy is threatened by the drugs. They can handle three or four different parties of ideological persuasion. They cannot handle drug lords who have armies bigger than that of the official government itself. And yet we will pass them off as a democratic government. You cannot be a democratic government and at the same time have a military that is inferior to that of the number one threat to open and free discussion.

Senator DODD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you, Mr. Chairman.

Senator Dodd and Senator Weicker in his opening statement I think hit a very important point, and that is we in Congress are great at doing a superficial, what looks like we are really doing something, rather than really, for example, providing funding for treatment centers.

But part of really doing something is dealing not simply with the effect, but dealing with the cause. You use the phrase a lot of times: "Up with hope, down with dope." You used the word "hope" several times in your testimony.

How do we give people hope, so they don't move in this direction?

Reverend **JACKSON**. Well, there are several dimensions as I see it. First of all, I want to go back over this one more time. If there are some youth who can show us where Uzis and AK47s are being sold across the counter—and I am telling you, I can deliver them here—will you follow those youth to where those guns are being sold and close that gun shop?

That is a step toward regaining credibility. If those youth can take us to where the drugs are dropped at the ports, will we go with them and find out why the youth can find them and the law enforcement officials can't?

I ask the children—literally, children—"Do you believe that the Government could do more to stop the drug flow?"

The answer is: Yes.

I say, "We are doing the best we can."

They say, "That's not true." They say, "If we can find the drugs at the port, so can they. If we can buy the weapons, so can they."

I say, "Well, I saw in the paper the other day where the law officials seized a big box of drugs."

They say, "Be serious. They get about one-fifth for the cameras, and then they recycle them and sell them right back to us."

That level of distrust in officials by those who sell them is a part of the problem. We must have, with all of our authority, appropriations and military authority, moral authority. We who would fight this struggle must first be believable ourselves. It seems to me it involves some action by us in both our official and non-official capacity.

I would say this. If we begin to bust some bankers laundering that money and some gun dealers who are renting and selling those guns, and if some officials would turn their heads as those planes land near our borders, we will be able to regain our youth, because our youth are buying the drugs and guns from adults—indeed, sometimes, from officials themselves. So we are weakened morally unless you make that basic change.

Second, convene these heads of state.

I would say this in conclusion, Senator Simon—several dimensions. One, diplomatic. Our Secretary of State must see that with all of the movements around the globe, to protect the security of our country, (a) the Secretary of State has a role to play, diplomatic, in this war on drugs, because it is a dimension of our foreign policy; (b) economic development in areas where drugs are grown the most. The poorest people in drugs become their number one cash crop; (c) militarily, we should back up our Coast Guard, satellites and our latest technology to detect the drug flow; (d) clinics—those who are sick need to get well; (e) mass education at the earliest levels; (f) morale and morality; and lastly, hope. When hope is on the rise, dope is on the decline. And for many of our youth, the sense of aimlessness is closed in on by drugs, and it is mighty profitable.

Senator **Simon**. Thank you.

The **Chairman**. Senator Harkin.

Senator **Harkin**. Thank you, Mr. Chairman.

I really don't have any questions. I think Reverend Jackson has really outlined a comprehensive proposal on how to deal with drugs, and again, I just want to say to you, Reverend Jackson, my deepest thanks for your lifelong leadership in this area. I know of no one else on the American scene today who has crystallized this issue as you have crystallized it, and has really made it into an understandable dimension for the people of this country.

I also want to thank you for speaking about it in terms of justice and fairness and equity. Every time a young person sees a rich person get off the hook, free, when they have been pushing drugs, they must say, "If only I am big enough and rich enough and powerful enough, I can get by with it."

When a John deLorean gets caught on film, delivering drugs in a hotel and goes scott-free, these young people say, "If only I was rich enough and big enough and powerful enough, I could get off too."

So I think what you have done is you have added a coherent dimension to this, a dimension of fairness and justice and equity. And I think that is what these young people really want in their lives, too. So I really want to compliment you for that.

Reverend Jackson. The second-biggest joke after the astrological chart reading in the White House was busting a yacht with some marijuana butts. That was seen as absurd, almost vulgar as a diversion, because it is so utterly unserious.

I tell you, as I have traveled through our schools, whether in the heart of Iowa, as you know, or Big City, U.S.A.—I speak to 12,000 to 20,000 children every week of my life for the last 20 years, except summer—when I ask 5,000 youth in the heart of Naperville, Senator Simon, "If you know someone who is dead because of drugs, stand," and 25 percent stand invariably, and then I ask, "If you know someone who is in jail," and about 40 percent stand, and then, "If you know someone in your school who has tried drugs," about 90 percent stand—and sometimes I ask, "And what about the teachers? They almost always avoid it for professional reasons"—but they keep getting louder.

And then I say, "If you know someone in your age group who has contemplated suicide, stand." And that is when the tears flow, because at that time, about 60 percent of our children almost always stand when asked have they contemplated or know someone who has contemplated suicide.

So let us approach this problem sincerely, comprehensively, pay for the fight, because there is on security threat today, there is no street threat greater than the drug flow.

Reagan has embraced Gorbachev as a new-found friend. We cannot embrace these drug dealers, ever, as friends. And Gorbachev is not nearly the threat to us because we have counterbalancing mechanisms on a Gorbachev; we have at this point no counterbalancing mechanisms on drug lords—almost no counterbalancing mechanisms.

The **Chairman**. Senator Adams.

Senator **Adams**. Thank you, Mr. Chairman.

Reverend Jackson, it is a pleasure to see you again. I appreciate very much your comprehensive statement and I support your views with regard to treatment and education programs.

I am especially concerned about one aspect of the drug crisis which is now before us; namely, the interdiction of drugs flowing in to our nation. My first question: From my experience as a United States Attorney I have found that the less expensive drugs are, the more dangerous they become; the wider-spread the use. Do you agree with that?

Reverend JACKSON. No question.

Senator ADAMS. A lot of people don't seem to accept that. It just seems to me that the use of "crack" and cocaine, which used to be a less expensive and less potent drug, is now at a much, much more widespread level than ever before.

I think that was part of the point Senator Kennedy was making. The great changes that have occurred over the last five years, are just startling.

Do you agree with that?

Reverend JACKSON. Yes, I do. But I am also concerned that—back to Senator Harkin's statement—that we have so glorified sex without love, making unhealthy and unwanted babies as standard operating, acceptable procedure for socially-acceptable before; we have so glorified liquor and sex and cigarettes as the ideal American, until that very psychological warfare is being inverted—it is being inverted. A freedom that results in death is foolishness. There is a certain foolishness factor here. We are not counting the cost or the impact on our children's minds.

This combination of sex without responsibility, of short-term pledge and long-term playing, covered up with anesthesia, make quick drug money, quick fix is creating a weakened American person.

Senator ADAMS. I agree with you completely. I think that this is the greatest threat to our society. I would like very much your comments about both a "drug czar" and about interdiction. I am concerned that in certain parts of the world—Central America in particular and portions of all Latin America—we have a situation where we created a narco-military establishment because we have placed drugs secondary to Communism and have dealt with people. I think that is part of our foreign policy dilema, as I believe you stated, in that we must deal in diplomatic terms but, in some of these governments, the government itself is owned by a narco-military establishment.

Reverend JACKSON. I am convinced that is true. The question is how far up in our Government are drug lords influencing.

Senator ADAMS. That has been part of it. Yes.

Reverend JACKSON. You see, it is one thing to look at the chip in their eye, but I want to look into our own eyes. We know how far drug czars have gotten up in some of those governments. But my friends, if we are buying $150 billion worth of drugs a year, the drug influence may be higher up in our own Government than we have faced. I think we must.

Senator ADAMS. I thank you very much.

Reverend JACKSON. When we have the Noriega situation hanging out there, we know what he was doing, we know that he got a job description, we know he got on our payroll, and somebody signed the check—at as much money as we pay our own President. And then the romance went sour, and then they bounced back and began to offer that man reprieves, before our children and the whole world.

My friends, I believe that a strong nation must have a strong military and a strong economy—but moral authority is the foundation upon which great nations are built. When we lose our moral authority, we not only lose our defense, we lose our children. That is my concern. If we regain our children, that's a major step forward toward regaining our sense of national greatness.

Senator ADAMS. Thank you very much, Reverend Jackson.

Mr. Chairman, I ask unanimous consent that my opening statement be included in the record.

The CHAIRMAN. Fine. It will be so included.

Senator Metzenbaum.

Senator METZENBAUM. Reverend Jackson, good to see you again. You have time to make your 11:30 appointment.

I first want to say it is good to see you again. Secondly, I want to say that I think it is quite incredible how you have become the outstanding spokesperson for the Nation's effort to do something on the subject of drugs, and you have been able to bring young people onboard with you. I have seen you galvanize young people into unbelievable kinds of reactions. And I think it is fortunate that you have addressed yourself so strongly to the issue of drugs. As a matter of fact, I don't know of anybody else—many others have had more TV time than you, but I don't think anybody has been more effective in using his voice in order to provide leadership on this subject, and I think all of us are very grateful to you for your efforts in that respect.

I know others have covered other subjects today, and I don't want to get into a repetition of that. But there is a matter that is proceeding through the Congress, and I would like your reaction on it.

I don't know of anything that bothers me more and has been more disturbing than when I visited a hospital and saw the AIDS babies, most of whom were babies that were dropped there by drug users who had the baby, left the hospital and didn't come back for the baby, and the baby has a very short life expectancy.

We have legislation pending that I think is about to become law—I think we are just about to conclude the matter with the House—to provide for taking those children, those tiny little babies, and putting them in boarder houses, in the home of some person who would be willing to care for the child during its short life expectancy. I don't know whether you are familiar with that legislation or you have any comment on it, but I thought that while we were here today, I might just ask for your reaction and whether or not you have been exposed to this particular aspect of the drug problem.

Reverend JACKSON. These children deserve our utmost attention. This crisis of AIDS, we are not sure, it seems to me, yet, where it comes from. We do know what it does—it kills people. And therefore, increasing the investment in the research must be high up on our agenda. But these babies deserve as much human care as we can afford them for their short expected lifespan.

I just hope that we can see the drug crisis in the kind of depth of question that you raise, because another gunboat won't solve that problem, which means that gunboats become just a part of a comprehensive plan. So, from prenatal care to those born with AIDS which they caught from their parents, or those born with other forms of drug addiction, it must begin from that level, therefore, all the way to the biggest pusher.

Senator **Metzenbaum**. Thank you very much.

The **Chairman**. We want to again thank you for your appearance, Reverend Jackson.

H.L. Mencken once said, "For every complicated problem, there is a simple, easy answer, and it is wrong." And I think you have reminded us today about the complexity of the issue; you have brought, I think, with extraordinary vividness what is happening in the schools, what is happening in the minds of the young people in this country, in ways which are very special and very unique. And hopefully, you are reminding the American people that this is going to take some time; it is going to take some energy; it is going to take resources, and it isn't going to be a simple, easy solution. It is going to really involve the best instincts and strongest commitment and a sense of continuity over a long period of time.

I think this Committee has benefitted from your insights which have developed and have been shaped over a long period of time and which are built upon your own strong sense of moral belief and deep feeling. I want to thank you very, very much for your appearance.

We will recess the hearing for three minutes and then get on with the rest of our witnesses.

Thanks very much.

[Short recess.]

The **Chairman**. The Committee will come to order.

We have got a very important hearing this morning and some, I think, enormously significant witnesses, so we would ask everyone's attention, and we will ask everyone to take their seats. Our witnesses are entitled to be heard.

Our next witness is the First Lady of the State of Utah, Mrs. Colleen Bangerter. We are delighted to have her with us today, and I am going to recognize Senator Hatch to have the honors for a full introduction.

Senator **Hatch**. Well, thank you, Mr. Chairman.

I am pleased to introduce to the Committee today Mrs. Colleen Bangerter. Mrs. Bangerter, as Senator Kennedy has said, is the First Lady of the State of Utah, and both she and the Governor have taken an active role in fighting the war on drugs. I am pleased that she is here to share her expertise with this Committee.

Mr. Chairman, she is currently the Honorary Chairman of the Utah Federation for Drug-Free Youth. She also is the Honorary Chairman of the Governor's Task Force for Youth, Drug and Alcohol Abuse, and is on the Advisory Board of the KUTV Drug and Alcohol Abuse Committee.

I want to thank you, Mrs. Bangerter, for your efforts to stop drug abuse among Utah's youth. You have had a real dramatic effect. These are honorary positions, but you have picked them up and run with them and have really made a difference in our State. I want to welcome you to this Committee hearing. We look forward to your telling us a little bit about the results of your many efforts in Utah, focused on reducing the demand for drugs among our youth.

We appreciate the efforts you have made to be here, travelling all night long. We are glad to have your testimony today.

The CHAIRMAN. Mrs. Bangerter, we are delighted to hear from you.

STATEMENT OF COLLEEN M. BANGERTER, FIRST LADY, STATE OF UTAH

Mrs. BANGERTER. Thank you.

It is an honor to be here to testify, and I have enjoyed listening to the Reverend Jackson's comments, and I commend him for all the work he is doing in substance abuse prevention.

There is a war going on in America, and vigorous efforts must happen now by American families, by Federal, State and local officials, by community organizations. This must happen now, because our most precious natural resource, our children, are being assaulted by drugs.

I appreciate the opportunity to testify at today's hearing. Mr. Chairman, thank you for scheduling this hearing, and I appreciate both your and Senator Hatch's support for efforts to reduce the demand for drugs.

My testimony today represents many thousands of Utah parents, educators, prosecutors, law enforcement personnel and citizens, whose story I am proud to tell.

Utah, like other States, has not won the war at this point, but we are making progress. And I believe with what we have learned, we can continue making great progress. The battle we are fighting is not easy. We are not fighting for nations or territories or even for control of mighty oceans. We are fighting for our Nation's youth.

The enemy is the cunning mercenary who cares nothing for the lives that he wastes. He is the drug seller, the pusher and the dealer. He is the trafficker. He is the one who says nothing about the use of drugs. He is getting rich while destroying others.

Across this Nation, over 38 million people have used illegal drugs. We spend over $100 billion each year for illegal drug-related costs. Between 1984 and 1987, cocaine-related deaths in 25 major metropolitan centers more than doubled, and cocaine-related emergency room visits tripled. These statistics vividly describe the crisis our country is in and the need for urgency and commitment to winning this war.

Utah is one State fighting this battle that sees no boundaries. What is a common problem with a common enemy has all too often not had a common solution. But a three-pronged approach—prevention, interdiction and prosecution—is the way to stop drug abuse. We have learned in Utah that one effort cannot work well without the other.

My remarks today will focus on the youth of our State and the prevention programs for them. While we have not forgotten those over 25, we strongly believe that if we can prevent this disease in children and youth, we will probably not have to treat it later in life. As you will see, these programs are beginning to work. They are working because everyone is involved.

First, I want to acknowledge Utah's accomplishments in our Alcohol, Drug and Tobacco Prevention Education Program, called the K through 12 Program. It reaches all public school grades, and it starts with kindergarten, and will be highlighted later in today's testimony by Mary Lou Bozich.

Second, we have worked to involve the spouses of Utah's local, State and national officeholders. Last August, I organized a meeting of Utah's First Ladies. I urged them to become informed about substance abuse in Utah, especially in fighting the denial of the problem, and support programs in their communities.

The First Ladies have helped to organize school and community groups. They have been able to focus attention on the problem.

Third, I believe that appropriately supervised peer counseling programs are very effective in both preventing and stopping drug abuse. The Utah Federation of Parents for a Drug-Free Youth, of which my husband and I both are members, received an ACTION Agency grant to carry out a program called Project Teamwork. Ninety-eight percent of all Utah schools participated by declaring a war on drugs and setting goals within their own schools to become drug-free schools. Over 1,800 Utah teachers and principals and students joined together and received training on how to deglamorize drugs and any pressure to use them. My husband and I visited many of these training sessions, and they were worthwhile, and they were very successful.

At on school in Utah, the teen counselors identified 14 kids who they believed were at high risk. The trained teens joined to steer these 24 away from drugs by including them in other school activities. And for many, this prevented drug use. Some of the high-risk kids said, "It was the best day of my whole life. I never felt so good." And, "Now that we have started talking, can we keep talking?"

This program has become a foot in the door in preventing drug abuse among some Utah youth.

Another successful prevention project included many activities in Utah schools during the May "Red Ribbon Week". While some children joined the "Drugbuster Club", others participated in writing essays or drawing pictures geared to raise awareness of the menace that illegal drugs and alcohol abuse pose to our society.

Last year, over 10,000 Utahans participated in this prevention effort, with 800 teens running for a drug-free Utah, from one border of the State to the other.

In 1985, the Utah Federation for Drug-Free Youth helped to organize a Statewide youth network called "Utah's Youth REACH." This organization is helping promote prevention Statewide in a variety of ways. Youth REACH teens have formed the nucleus of peer helper groups for high schools through peer counseling, prevention assemblies, and prevention programs that are taken to junior high and elementary schools.

Our approach in Utah to curb drug abuse also requires strong criminal sanctions against those who would steal our children's minds. We also have strong interdiction efforts to apprehend and prosecute drug dealers.

Many of Utah's efforts have been supplemented by Federal funds. For example, our K through 12 Program is being partially supported by the Drug-Free School Act of 1986. Our Project Teamwork is being supported through the ACTION Agency drug volunteer program. And Utah needs to continue receiving Federal dollars for treatment under the Alcohol, Drug Abuse, and Mental Health Services Block Grant.

I urge you to continue these fine Federal programs.

But as you fashion these and other programs, Mr. Chairman, please do not forget that it is the States who bear the burden and responsibility of carrying out the mandates of these programs. It is essential that there exist a true Federal/State partnership as we all seek to address and solve the problems of substance abuse among our citizens.

In the spirit of true federalism, you must grant my husband and the Governors of all of the States sufficient flexibility and control over these programs. They can craft individual and unique solutions to this common problem.

The war against drugs will not be won because the Federal Government is willing to spend billions of dollars. The war will be won when all Americans are included in this battle. If we all work together starting, most importantly, with each of our own families and then our communities, we will win the deadly war of drug abuse, because after all, Mr. Chairman, where there is no demand, there will be no supply.

I would like to end on a personal note. There have been many people who stop me and ask why Norm and I spend so much time on this issue. There is really only one reason. I, like you, Senator Kennedy and you, Senator Hatch, have children, and I have grandchildren. Let us work together for their future free from drugs.

Thank you very much.

The CHAIRMAN. Thank you very much for your very helpful testimony. And obviously, with your own strong personal involvement, you have given, I know, a special life to that whole program in the State. So I think you are really to be commended.

What is your sense, having been involved in the Utah program—how early do you think young people ought to be exposed to education or peer group involvement? Where should all of that really start, at what age?

Mrs. BANGERTER. I think it should start immediately, in kindergarten. Our K through 12 Program is so important. I am so impressed with this program because it involves families.

The CHAIRMAN. So you start as early as kindergarten?

Mrs. BANGERTER. Yes. These children have little stories, they have questionnaires they take home to their families, and they work on this together as a family. They bring it back to the schools, to the teachers. When we talk about education, I think we have to state that it has to be effective education.

The CHAIRMAN. Yes.

Mrs. **Bangerter**. I visited a beautiful young girl in one of our rehabilitation centers in Utah, and I asked her, "Did you know the consequences of taking drugs? Did you know the effects that they would have on your body?"

She said, "Yes. I did a report on it."

But I also learned that this young lady was going through a crisis in her life where her parents were being divorced, her family was being torn apart, and she couldn't cope with these problems.

So I think we really have to instill those coping skills, building self-esteem.

Also, I asked a young man at one of our rehabilitation centers why he got involved in drugs, and he replied, "Because it was just there. It was available."

So I think we have to be careful that we do stop that availability of the drugs, and I do believe we have to start at that young, young, early age.

The **Chairman**. Thank you very much.

Senator Hatch?

Senator **Hatch**. Thank you very much, Mr. Chairman.

I do have some questions, but I'll defer them, and just say how pleased I am to have had you here today, and also you, Ms. Bozich.

I have other commitments that I have to go to, but I just want to thank you for making the extra effort to come here. It has been very helpful; we are proud of what you are doing out there in Utah, and we want you to keep it up.

Mrs. **Bangerter**. Thank you very much. It has been a pleasure, Senator.

[Response to Mrs. Bangerter to questions of Senator Hatch follows:]

STATE OF UTAH
OFFICE OF THE GOVERNOR
SALT LAKE CITY
84114

NORMAN H. BANGERTER
GOVERNOR

On June 16, 1988, Mrs. Colleen Bangerter gave testimony at a hearing on drug abuse prevention, education and treatment before the U.S. Senate Committee on Labor and Human Resources. Following are responses to questions regarding federal substance abuse initiatives.

1. Do the states have sufficient leeway to set priorities for their drug programs financed in part by federal block grants?

This questions has several answers depending upon the area of focus and concern. Several responses will be given:

-State and Local Assistance for Narcotics Control - The response to this area is yes. The strategy devised is solely a state creation. The seven general purpose areas allowed for law enforcement funds are appropriate.

-Prevention and Treatment Block Grants - In these two areas there is concern that the states may not have sufficient latitude in setting their own priorities - especially if future legislation becomes more restrictive as to use of funds. States need to have considerable latitude is deciding the priorities for prevention and treatment activities. However, we are supportive of federal legislation requiring that a minimum of funds received be spent on prevention activities, otherwise, treatment demands may totally dominate available funding.

2. Do you think the federal government is currently providing a sufficient share of the costs of running state drug prevention and treatment programs?

This question has a separate response for "treatment" and "prevention" programs:

-Treatment - In this area it is felt that there are insufficient federal funds allocated. There is also concern regarding future stability of funding. Utah saw very little in the way of federal demonstration funds.

-Prevention - In general, there has been adequate federal support for prevention programming. Help will always be needed in identifying programs and methods that are effective in preventing use/abuse.

Serious concern has been expressed over future federal matching requirements and the state's ability to provide the necessary funding.

3a. Do you believe the federal government should evaluate education and treatment programs?

The answer is definitely yes! The federal agencies responsible should evaluate the general programs to include some subgrantee activities.

There is also a great need for states to receive direct, onsite training and technical assistance (TA) regarding evaluation strategies, methods and instruments. The federal government should assist states in developing their capacity to conduct quality program evaluations. The states should be allowed to set their own criteria with TA help. Additional funding is needed for this activity.

3b. Does the state of Utah evaluate their programs?

The state and local agencies provide various types and levels of evaluation. The current k-12 programs in the public schools has been conducting a longitudinal evaluation for the past six years. This has been conducted with limited funding. The evaluation has centered on teacher training and the impact of the curriculum on students over a long time period. Most evaluations are of a process nature. A few are structured for outcome assessment but are usually restricted in scope because of a lack of funding. Most projects are informally evaluated through on-site visits and grantee progress and annual reports. This is an area where evaluation, TA and additional funding would be helpful.

The CHAIRMAN. It is really helpful to our Committee to find out what is happening in Utah. As I said earlier, you deserve a lot of commendation for the work that you personally are involved in. It is a great example.

We want to thank you very, very much for your appearance here.

We are going to ask one of our witnesses to testify out of order because he needs to leave shortly, and then we will proceed with the panels.

We are pleased to welcome back to the Committee, David Weikart, the President of the High/Scope Educational Research Foundation in Ypsilanti, Michigan, and he will tell us about the High/Scope studies in the area of early childhood development.

We have good panels today and, I think, a fascinating hearing for the rest of the morning, but as we can all tell, we are running short on time, so we'll ask all of our witnesses if they would be kind enough to summarize their statements. We will include all the statements in the record in their entirety.

We are delighted to welcome you, Mr. Weikart.

STATEMENT OF DAVID P. WEIKART, PRESIDENT, HIGH/SCOPE EDUCATIONAL RESEARCH FOUNDATION, YPSILANTI, MI

Mr. WEIKART. Thank you for the opportunity to be here, Senator. I believe that my official comments will be submitted to the record, and I just want to make a few summative comments at this point.

One of the most interesting things about listening this morning, both Senators Simon and Weicker, as well as Reverend Jackson, talked about early education. Education at the preschool period is, really, prevention rather than education. Direct teaching of concepts about drugs and drug use is difficult at that age.

One of the most interesting things we know about early education is that it does have some long-term permanent impact on young children.

There are two charts displayed. First, High/Scope Perry Preschool Project illustrated the long-term impact that high-quality programs can have on young children. Positive impacts include increasing high school graduation rates, improving higher education participation rates, improving literacy, and of course, important from the economic side, is improving employment. Results also include, reduction of welfare utilization and reduction of the number of young people arrested.

It is interesting to note the arrest rate for this very small sample in one community in Ypsilanti, Michigan. The arrest rate for the control group is the same as the national average for children like themselves, while that rate for the group with preschool education has been reduced almost in half. Early childhood education is not the solution; it cannot be the only solution; but it appears to be part of the solution.

Other studies in addition to High/Scope's have been finding a link to delinquency at age 15 year-olds. The study from Syracuse University, by Ron Lally and his staff, has been following a group of young people from a high-quality day care program. They report a significant reduction in the occurrence of delinquent behavior by age 15 between the group who participated in the program and the group who did not. These findings parallel very closely what we are finding in the High/Scope studies.

One of the most interesting things we have been coming across, now, are new findings relating to the effects of types of early education.

Perhaps more important to this panel is the fact that we have been discovering a differentiation in drug use based on kind of preschool program attended. Those programs designed to impart facts, knowledge, direct skills to children through direct teaching do not appear to be as effective in reducing both hard and soft drug usage as those programs which are more child-oriented or child initiated.

These child-initiated programs, the type approved by most of the national groups that deal with young children, such as the National Association of Education of Young Children, and the Elementary School Principals Association, have less than half the amount of hard drug usage than the groups direct instruction.

In child-initiated programs one-half of the children tried hard drugs by age 15, while in the group with direct teaching programs, each child had tried hard drugs more than once by age 15. This early pattern of drug use suggests longer-term problems of major proportion.

The question, of course, is why would something that happened at age 3 or 4 like early childhood education possibly have any impact upon behavior at ages 15, or 20 and later. In a sense, the old adage simply holds true: As the twig is bent, so the tree will grow. Or, more specifically, programs designed to give the child decisionmaking responsibility do not create dependency in the child. Knowledge is produced by the child through his own actions, his own decisions. He or she has control of self.

Such child-initiated programs give great success in skills and abilities that relate to school and school-like behavior, and as a result the child feels a real sense of self-esteem based upon actual performance.

And finally, there is a real development of self-confidence and ability in children, specifically as it relates to strange new adults, teachers, others in the school.

Early childhood education programs, including day care, are indicating very strongly that we can create a platform for child growth and development which is very useful for the future.

The important aspect is not so much that such programs are training specifically related to the prevention of drug use or of drug abuse, but that they give the child options, opportunities and skills to make better decisions with their lives as they grow up.

Such decisions show in the Perry Study, for example, in the reduction of teenage pregnancies. As girls have something to do with their lives and make personal decisions, they elect not to get pregnant. The platform that is developed by children at this age determines the long-term outcome.

I believe the focus that the Senate is giving bills, such as your own Smart Start and others, have increasingly recognized the importance of this period of development and they will do much to help deal with the drug problem.

I would like to close again with the fact that while we know that prevention, particularly at preschool periods, can be very effective, we are also aware of the fact that it is not the only solution. Other multiple-pronged efforts need to be included.

Thank you very much.

[The prepared statement of Mr. Weikart follows:]

HEARING TESTIMONY

Committee on Labor and Human Resources

David P. Weikart
High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, MI 48198

Thursday, June 16, 1988

Senator Kennedy and members of the Committee, I am David P. Weikart, president of the High/Scope Educational Research Foundation, an independent, nonprofit research, development, and training organization with headquarters in Ypsilanti, Michigan. The Foundation's principal goals are to promote the development of children from infancy through adolescence and to support teachers and parents as they help children learn and grow. The Foundation conducts national and international projects in research, program development, professional training, publishing, and public outreach, with funding support from both governmental and private sources.

Today I will describe an eduation program that shows promise of reducing drug abuse in the nation's young children living in poverty. Current efforts related to drug abuse prevention have caused many of us to questions whether anything can be done to alleviate the suffering, anti-social behavior, and lawlessness associated with the use of drugs in our society. Clearly there are no magic solutions and certainly no simple answers. Yet, longitudinal research on the effects of high-quality early childhood education suggests such programs can contribute to the amelioration of such problems. Specifically, after a brief overview, I will present the basic findings from longitudinal studies of preschool children. After this I will discuss the issue of quality and will review some of the limited data available on this issue. Finally, I will present several policy concerns for committee consideration.

Children at Risk in Poverty

Statistics about the problems substantial numbers of America's children face as they grow up in our society raise troubling issues these days. The 1985 Census data, show that 25 percent of American children live in poverty. Up to 14 percent are children of teenage mothers. Some 40 percent of our children will live in single-parent homes before they reach the age of 18. Over 10 percent will have poorly educated and possibly even illiterate parents.

Over 25 percent will never graduate from high school. These statistics are for America's children in general. When we move to minority youngsters the data become even more serious. For example, a black child is three times more likely than a white child to be born into poverty. An Hispanic child is more than twice as likely to be poor. Problems of the "persistent poor", those who we expect will live in poverty for more than 10 years, present the worst case. While only about 4 percent of all children fall into this category, 90 percent of the persistent poor are black and a significant majority of these lack a father in their home and live in the rural south. (1)

To be born poor and to grow up poor leads to major problems for the child and ultimately for society. Consider these facts: Black and Hispanic children score below white youngsters in standardized achievement tests. The average scores for blacks and Hispanics on scholastic aptitude, verbal ability's and mathematics are more than 100 points lower than the scores of whites. The same division is found on the tests administered by the National Assessment of Educational Progress Studies. The dropout rate continues to be extreme for non-white youths. More than three fourths of white youths will graduate from high school, but less than 60 percent of all blacks and slightly more than 50 percent of all Hispanics will graduate. (2) The new tendency to ensure high-quality education by tightening graduation requirements and promotion policies, which is drawn from the recent reform effort, will probably reduce even more the school completion rate for minorities. (3)

Crime statistics are comparable to the education statistics. Disadvantaged minority youth have a 50 percent arrest rate by age 21; the national average as a whole reaches approximately 18 percent. Clearly, disadvantaged children, without some type of prevention, have unacceptably high rates of delinquency, crime, and drug abuse. For the sake of our society, we must take steps to reduce these problems.

History of Early Childhood Education

Child education and care services in the United States are based on a history of some strongly held social, political, and economic beliefs--such as an individual's right to independence and self-determination, limitations on central governmental control, and a free-market economy. Considering these beliefs, it is not surprising that to protect parents' rights and responsibilities in decision-making regarding their children, no single education and care ideology has been accepted on a national scale. Instead, various options have been developed in the United States.

The first American day nurseries for children in need were established by philanthropists and charity workers in the 1870s and 1880s. These nurseries' main purpose was physical care of the children (feeding, bathing, keeping them safe from the dangers of the street) six days per week, 12 hours per day. The day nursery, however, was considered a last resort for children who could not be cared for at home, a necessary evil to be endured only by children whose mothers "had to" work.

In 1933, to alleviate effects of the Great Depression, President Roosevelt helped make public funds available for the expansion of day care via the Federal Economic Recovery Act and the Works Projects Administration. Later, during World War II, women were mobilized into war-related industries. National financial support for day care came in the form of the Lanham Act of 1942; day nurseries flourished as public disapproval of women in the paid work force was apparently superseded by patriotism. After World War II, the Lanham funds were withdrawn with the expectation that centers would close and women would return to their homes.

In the early 1960s, concern was expressed by educational and social welfare authorities concerning the quality of care and the lack of educational opportunities available to poor and working-class children in their own homes as well as in unregulated preschools, day care homes and centers. The war on poverty was the result.

The Role of Intervention on Intellectual and Social Development of Children

The available evidence suggests part of any solution to the prevention of major social and personal problems in adults is to provide high-quality preschool child development programs for them when they are young. This idea for prevention first became popular among leading educators and social scientists in the 1960s and led to the establishment of National Head Start. It also led to a variety of experimental programs and, in accordance with the spirit of the times, to a limited number of scientific evaluations of the effectiveness of these programs. Despite some early findings and some recent echoes that cast doubt on the overall efficacy of the national Head Start program, the findings of carefully drawn studies of preschool child development programs suggest a possible pattern of causes and effects that stretches from early childhood into adulthood. (4)

Poor children are likely to perform poorly as they enter school because they have not developed, to the same extent as their middle-class peers, the skills, habits, and attitudes expected of children in kindergarten and first grade; this lack of development is manifested in low scores on tests of intellectual or scholastic ability. Children who have not developed in this way may be developmentally advanced in other respects not relevant to school success. Their lack of preparedness for school, however, can lead to unnecessary (that is, preventable) placement in special education or retention in grade, low scholastic achievement, and eventually dropping out of high school. In adulthood, crime, delinquency, welfare dependancy, and drug abuse can be the result. Poor children who attend good preschool child development programs become better prepared in the skills, habits, and attitudes expected of them in kindergarten and first grade. Thus, they begin a more successful career in school that can extend into adult life. Perhaps the best known of these early intervention programs is High/Scope Foundation's Ypsilanti Perry Preschool Project. (5)

Ypsilanti Perry Preschool Project

The Perry Preschool Project is an ongoing study begun in 1962 of 123 black youths, from families of low socioeconomic status, who were at risk of failing in school. The purpose of the study was to explore the long-tern effects on these young people of participation versus non-participation in a program of high-quality early childhood education. Drawn from a single school attendance area, at ages 3 and 4 these youngsters were randomly divided into an experimental group that received a high-quality preschool program and a control group that received no preschool program. Information has been collected about these youngsters on hundreds of variables has been collected and examined annually from ages 3 to 11, and again at ages 14, 15, 19, and now at age 28--assessing family demographics; child abilities, and scholastic accomplishments; and involvement in delinquent and criminal behavior, use of welfare assistance, and employment.

Results

The long-term study of these 123 youngsters, following them from program entry at age 3 to young adulthood at age 19, has provided important information on the impact of early education on future growth. On the whole, early childhood education significantly alters the child's performance in later life.

Results at age 19 comparing those who attended preschool and those who did not can be summarized as follows:

In education--

- Fewer classified as mentally retarded (15% vs. 35%)
- More completed high school (67% vs. 49%)
- More attended college or job training programs (39% vs. 21%)

In the world of work--

- More hold jobs (50% vs. 32%)
- More support themselves by their own (or spouse's) earnings (45% vs. 25%)
- More are satisfied with work (42% vs. 26%)

In the community--

- Fewer arrested for criminal acts (31% vs. 51%)
- Lower birthrate (64 vs. 117 per 100 women)
- Fewer on public assistance (18% vs. 32%)

Economic Outcomes

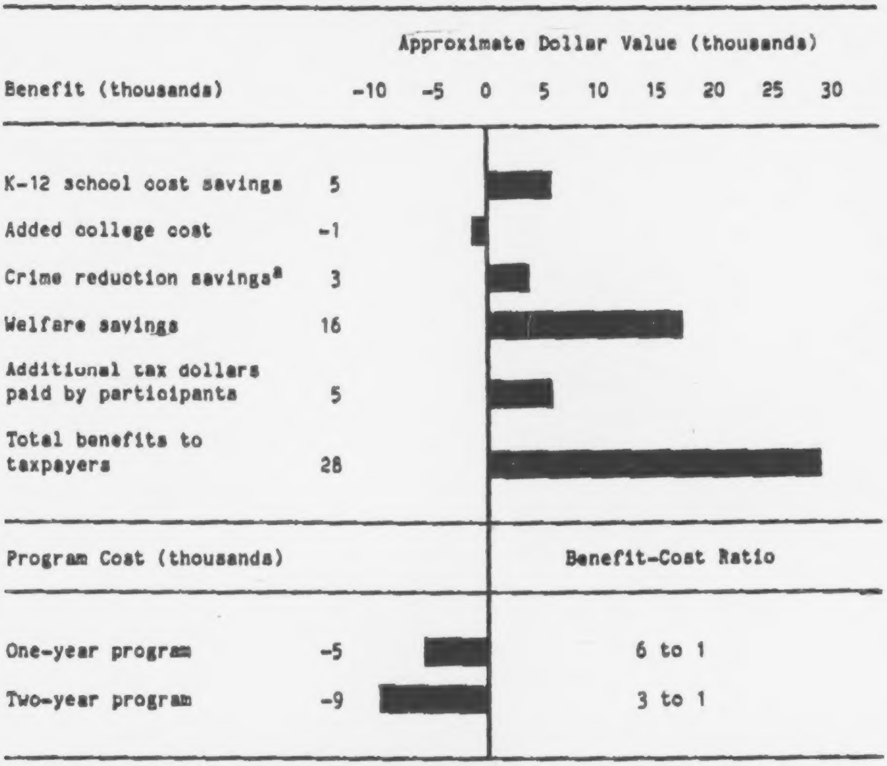
The cost-benefit analysis of the Perry Preschool program indicates that such programs can be a good investment for taxpayers. On the basis of a careful analysis of 15 years of follow-up data, this program showed a very positive value for taxpayers. (6)

Figure 1 indicates that the major cost of the program (in constant 1981 dollars, discounted at 3 percent annually) is the initial investment of about $5,000 per participant per program year. (It is important to note that this cost figure includes items of school operation that are usually overlooked, such as building depreciation, clothing, volunteers, etc.) Major benefits found for the taxpayers were reduced costs per participant of about $5,000 for special education programs, $3,000 for crime, and $16,000 for welfare assistance. Additional post-secondary education costs by participants added about $1,000 to costs. Participants were expected to pay $5,000 more in taxes because of increased lifetime earnings (predicted from their improved educational attainment).

Thus, total benefits to taxpayers amount to about $28,000 per participant, which is nearly six times the initial cost of the one-year program, or three times the cost of the two-year program. The return is large enough that even a two-year program that was only half as effective as the one-year program studied would still yield a positive return on investment. The savings from reduced costs for special education alone are enough to return to taxpayers an amount equivalent to the cost of a one-year program.

FIGURE 1

PERRY PRESCHOOL PROGRAM PER-CHILD
COSTS AND BENEFITS TO TAXPAYERS



Note. Table entries are constant 1981 dollars, discounted at 3% annually. Adapted from John R. Berrueta-Clement, Lawrence J. Schweinhart, W. Steven Barnett, Ann S. Epstein, & David P. Weikart, *Changed lives: The effects of the Perry Preschool program on youths through age 19*, Monographs of the High/Scope Educational Research Foundation, 8 (Ypsilanti, MI: High/Scope Press, 1984), p. 91.

[a] Savings to citizens as taxpayers and as potential crime victims.

Quality in Early Childhood Education

The research findings cited above are not an endorsement of all early childhood programs. There is no intrinsic value in a young child's leaving home for a few hours a day to join another adult and a group of children. Program quality must be carefully defined and maintained or a preschool classroom or child care center is just another place for a child to be. The effects of preschool programs have been found for high-quality child development programs only.

A high-quality program is dynamic. It is not a matter of demanding difference of staff qualifications of the staff or even of additional financial for material resources of the program; what assures quality is continued focus on the appropriate use of staff skills within a curriculum. It is the process of curriculum implementation that produces a high-quality program.

It was this issue of defining quality that the High/Scope Preschool Curriculum Study addressed. In short, we asked ourselves, Is one curriculum approach more effective than another?

The High/Scope Preschool Curriculum Study

The ongoing High/Scope Preschool Curriculum Study began in the public schools of Ypsilanti, Michigan in 1967. It served three-and-four-year old children who lived in families of low socioeconomic status and who, according to test scores, were at risk of failing in school. The children were assigned to one of three curriculum models by a random-assignment procedure designed to ensure the comparability of the groups. The curriculum models all operated under similar administrative conditions and adhered to high standards of quality: a clearly articulated curriculum, ongoing training and supervision of staff, highly trained teachers, low teacher-pupil ratios, extensive parent involvement, and adequate resources. (7)

The curriculum models used in the project represented three major theoretically distinct approaches to preschool education. They differed with respect to the degree of initiative expected of the child and the teacher--whether the child's and the teacher's primary roles were to initiate or respond.

- The direct instruction approach sought to efficiently teach academic skills by scripting the teacher's role and encouraging frequent responses by children. (8)
- The traditional nursery school approach allowed children to initiate their own play activities, with the teacher responding to children's requests for guidance.

- In the High/Scope curriculum, children initiated their own activities, but the teacher also maintained an active role by arranging the room to promote children's active learning; making plans and reviewing activities with children; interacting with individual children throughout the program day; and leading small- and large-group sessions. (9)

Both the High/Scope and nursery school groups, at age 15, reported engaging in about half as many delinquent acts as did the direct-instruction group. If we define a high-rate offender as one who reported over 15 delinquent acts, 44% of the direct-instruction group were high-rate offenders, as compared with only 6% and 11% respectively for the other two groups. Furthermore, the High/Scope and nursery school groups each reported only about one fifth as many acts of property violence as did the direct-instruction group, and about half as many acts of personal violence, drug abuse, and in-family offenses. (See Table 1)

Table 1. Delinquent Acts Reported at Age 15 by Curriculum Groups

Variable[a]	Distar	High/Scope	Nursery School	*p*
Delinquency scale, 18 items, *alpha* = .83	12.83	5.44	6.94	.04
	(13.33)	(5.15)	(8.61)	
Personal violence subscale	2.28	0.88	1.17	—
	(3.30)	(1.11)	(1.92)	
Hit an instructor/supervisor	.39	.06	.00	—
Had a serious fight in school or at work	.72	.28	.56	—
Been in a group fight	.44	.22	.11	—
Seriously injured someone	.30	.28	.50	—
Used a weapon to get something[b]	.22	.00	.00	—
Property damage subscale	1.72	.28	.39	.04
	(2.89)	(0.57)	(1.14)	
Committed arson	.44	.00	.00	.06
Purposely damaged school property	.83	.29	.39	—
Purposely damaged work property	.22	.00	.06	—
Stealing subscale	3.06	1.72	2.22	—
	(4.18)	(2.44)	(3.04)	
Stolen something worth under $50	1.17	.72	.89	—
Stolen something worth over $50	.44	.11	.17	—
Stolen something from a store	1.00	.83	1.00	—
Stolen a car	.00	.06	.06	—
Stolen part of a car	.28	.00	.11	—
Used a weapon to get something[b]	.22	.00	.00	—
Drug abuse subscale	3.17	1.06	1.89	.06
	(3.22)	(1.43)	(2.85)	
Smoked marijuana	2.06	.78	1.39	—
Used other illegal drugs	1.11	.28	.50	—
Status offenses subscale	3.04	1.56	1.22	.04
	(2.71)	(2.04)	(1.73)	
Argued or fought with parents	1.94	1.11	1.00	—
Run away from home	.38	.17	0.00	.02
Trespassed	.72	.28	.22	—

Note. $N = 54$, 18 per group. Group differences on these variables were tested by analysis of variance; *p*-values are reported if less than .10. Standard deviations on summary scales are included in parentheses.

[a] Scales are sums of item scores; items are responses to the question, "Have you ever . . .?" scored: 0 to 2 = as indicated, 3 = 3 or 4 times, 4 = 5 or more times.

[b] Weapon use included on both personal violence and stealing subscales.

Specifically, the Distar group reported that they engaged in twice as many acts of drug abuse as did the other two groups, in use of both marijuana and other illegal drugs. This finding is important because it links, as expected, drug use to a general delinquency pattern. It also indicates that only high-quality child-initiated learning programs are effective in reducing delinquency and, thus, drug abuse.

What are the essential elements of a high quality program?

- A clearly stated, validated curriculum that features child-initiated activities. Based on recent curriculum studies, a high-quality curriculum accepts children at their developmental levels and provides ample opportunity for independent problem-solving, meaningful self-initiated conversations with peers and adults, and ample time for self-directed exploration of interesting, age-appropriate materials.
- At least two adults for each group of 16 20 children.
- A clear plan for ongoing inservice training and systematic classroom supervision in the curriculum methodology adopted with staff trained in early childhood education and care.
- Effective evaluation procedures that help the staff see how each child responds to the program environment.
- Active involvement of parents in the development and operation of the program.
- Good administrative support with clear links to comprehensive services such as health, nutrition, and social services.

Related Studies and Observations

The linkage of high-quality, child-initiated program to the reduction of crime and delinquency, and by inference of drug abuse, has been strongly supported both by other studies and by direct observation and experience. The Syracuse University study by Ron Lally and colleagues on a follow-up study of day care programs found effects on delinquency rates. Program children experienced a day care program throughout their first five years of life, while the control group did not. Probation and court records were examined when subjects were 13 to 16 years old. Only 6 percent of the program group (4 of 65) had been placed on probation, while 22 percent of the control group (12 of 54) were placed on probation. Only 2 percent of the program group were considered guilty of chronic or serious delinquency, as compared to 15 percent of the control group. These findings support more of High/Scope's Perry Project.

In a widely circulated June 1988 letter to Sophie Masloff, Mayor of Pittsburgh, Judge Judith Friedman noted "The results of the Perry study appear to confirm what I, and others interested in child care, have long suspected: that many social problems can be avoided or at least ameliorated by early intervention in lives at risk.

"As a judge in the Criminal Division of Allegheny County's Court of Common Pleas, I spend a good deal of time sentencing people. Pre-Sentence Reports are often ordered as an aid to forming a fair sentence which may help achieve our primary goal of rehabilitation. It has become apparent to me that in a large portion of the cases the best rehabilitation would have been prevention during early childhood. So often I see that by age 12 a pattern of indifference and apathy has been set, aggravated by the use of alcohol and, in some cases, drugs. The result is people who, by age 25 or 30, are virtually incapable of leading a normal life. It breaks my heart to realize that the only course for certain defendants is long-term incarceration--that they will probably never change. Fortunately, in Allegheny County, those hopeless cases are still in the minority. However, I have noticed an increase in such defendants and at much younger ages (18 or 19 rather than 25 or 30). It is my belief that we will soon begin to experience a significant increase in such young sociopaths.

"Other major cities already have substantial problems--L.A. has gangs, Detroit sees school children killing each other over minor disputes. Miami, New York, Chicago, Philadelphia--all have crime problems far worse than ours. But we are catching up. We have the chance to save some of our children from a future of crime and degradation. I urge you to seize the opportunity now to implement more Head Start programs, more preschool and more full-time child care centers, especially in our poorer neighborhoods, so that Pittsburgh and Allegheny County can contribute to be a truly great place to live."

Summary

Early childhood education, when operated with high-quality standards, can reduce crime and delinquency and there-by drug abuse. It is not a "cure-all" or a simple solution to a complex social problem. However, it is a direct and effective way to prevent a significant portion of such problems. When projects such as High/Scope's Perry Project were established, delinquency patterns did not include drug use. Now they do. Recent data from High/Scope's Curriculum Comparison study indicate that reduced crime and delinquency rates also include reduced drug utilization. The high-quality early childhood care and education are effective tools for attacking the nation's drug abuse problems.

FOOTNOTES

(1) Detailed presentation of these data are in Children in Poverty. (1985). Committee on Ways and Means, U.S. House of Representatives, U.S. Government Printing Office, Washington D.C. See especially pps. 3-14.

(2) A special section of Education Week, May 14, 1986, presented a special report on America's Changing Outlook for Schools and Society. While the editors of Education Week preprared the report, they used, in part, the unusual data collected by Harold L. Hodgkinson of the American Council on Education.

(3) MDC, Inc., reached this conclusion after reviewing the work of various state commissions on excellence in education and reported it in Who's Looking Out for At-Risk Youth (Fall 1985). Charles Stewart Mott Foundation, Flint, Michigan.

(4) The two studies most noted are the Westinghouse Learning Corporation, The impact of Head Start: An evaluation of the effect of Head Start on children's cognitive and affective development, (1969). Vols. I-II, Athens, OH: Ohio University; and the very recent, McKey, R. H., Condelli, L., Ganson, H., Barrett, B., McConkey, C., & Plantz, M. (June 1985). The impact of Head Start on children, families and communities. (Final Report of the Head Start Evaluation, Synthesis and Utilization Project.) Washington D.C.: CSR, Inc.

(5) The project is presented in detail in Berrueta-Clement, J. R. , Schweinhart, L.J., Barnett, W.S., Epstein, A.S., & Weikart, D.P. (1984). Changed Lives: The effects of the Perry Preschool Program on youths through age 19. (Monographs of the High/Scope Educational Research Foundation, 8). Ypsilanti, MI: High/Scope Press.

(6) The first economic report occurred in Weikart, D.P. (October 1971). *Early Childhood Special Education for Intellectually Subnormal and/or Culturally Different Children*." Prepared for National Leadership Institute in Early Childhood Development, Washington D.C. The second report was in Weber, C.U., Foster, P.W., & Weikart, D.P. (1978). *An economic analysis of the Ypsilanti Perry Preschool Project*. (Monographs of the High/Scope Educational Research Foundation, 5.) Ypsilanti, MI: High/Scope Press. The most recent in Berreuta-Clement, J.R., Schweinhart, L.J., Barnett, W.S., Epstein, A.S., & Weikart D.P. (1984). *Changed Lives: The effects of the Perry Preschool Program on youths through Age 19*. (Monographs of the High/Scope Educational Research Foundation, 8.) Ypsilanti, MI: High/Scope Press. A full detailed account can be found in Barnett, W.S., (1984). *A benefit-cost analysis of the Perry Preschool program and its long-term effects*. Ypsilanti, MI: High/Scope Press.

(7) The findings of this new High/Scope Study are reported in Schweinhart, L.J., Weikart, D.P., & Larner, M. B. "Consequences of three preschool curriculum models through age 15." The National Association for the Education of Young Children's journal, *Early Childhood Research Quarterly*, *1*, 303-312, 1986.

(8) The original program is presented in Bereiter, C., & Englemann, S., (1966). *Teaching the disadvantaged child in the preschool*. Englewood Cliffs, NJ: Prentice-Hall.

(9) The High/Scope Curriculum is presented in Hohmann, M., Banet, B., and Weikart D.P. (1979). *Young Children in Action*. Ypsilanti, MI: High/Scope Press.

(10) The most recent report on this study is Lally, J.R., Mangione, P.L., and Honig, A.S. The Syracuse University Family Development Research Program: Long-Range Impact of an Early Intervention with Low-Income Children and their Families is Powell, D.R. (Ed). *Parent Education and Support Programs: Consequences for Children and Families* (to be published).

The **Chairman**. Thank you very much.

As we will be fashioning and shaping the prevention, education and rehabilitation aspects of the legislation, do you think it would be useful to add an appropriate early education component to that?

Mr. **Weikart**. Very much so. I think the power of this age period for establishing the framework for young adult growth is well-documented. I think any program must include early childhood education. It is such an important period of time.

The **Chairman**. We had a chance the other day to see in Boston the High/Scope curriculum being used in one of our Head Start programs just being initiated about ten days ago. It is increasingly accepted, and wisely so, across the country, and we have a lot of respect for those who have been involved in shaping it and developing it. I think it has made a very extraordinary contribution.

I am sure we will be keeping in close touch with you, asking for additional information, and as the various studies, reviews and evaluations continue, I hope you will keep us informed, because it has been enormously helpful and valuable to all of us on this Committee and in the Senate.

Mr. **Weikart**. Thank you. We certainly will do so.

The **Chairman**. I thank you very, very much. Our next witnesses will show us our first line of defense, really, against the dangers of drugs. We will hear from Freddy Torres, from East Boston High School, who will tell us about his program of helping classmates up in Boston, and we will also hear from Tom Hedrick, who heads up the Partnership for a Drug-Free America, which is doing a wonderful job trying to get the message across to young people and people of all ages across the country about the dangers of drug abuse.

We thank you very much for being with us, Freddy, and we are grateful to you for coming down. You have a very important story to tell us, and we hope you will feel that you are among friends here. We look forward to your comments. I think people can learn a great deal from your own experience, so we hope you'll just tell us as it is, and we want you to know we are grateful to you for joining us today.

STATEMENT OF FREDDY TORRES, EAST BOSTON HIGH SCHOOL, BOSTON, MA; AND THOMAS A. HEDRICK, JR., EXECUTIVE DIRECTOR, THE MEDIA-ADVERTISING PARTNERSHIP FOR A DRUG-FREE AMERICA, NEW YORK, NY

Mr. **Torres**. My name is Freddy Torres, and I am a junior at East Boston High School in Massachusetts. I have lived in East Boston all of my life and attended the Boston public schools.

I am 17 years old and the youngest of 13 children. We have a very close family, and my brothers and sisters have been a great influence on my life. Two of my brothers are members of the Boston Police Department and at times, it seemed like a lot to live up to.

When I was in eighth grade, one of my brothers was involved with drugs. He was a really good student, and in his senior year, he began hanging around with the wrong crowd and using drugs. He could have gotten a scholarship to any college, but he started missing school, and his grades fell off. It seemed that drugs were more important to him at that time. Now, he is in and out of different jobs, but he has stopped using drugs.

When I started high school, the teachers already knew me, because they had all known my brothers and sisters. It was really different being in high school, and there were a lot of different pressures. Lots of kids were doing drugs, and even the elementary school kids watched drug dealers hanging out on the street corners near my house. After 7:00 at night, all you had to do was walk out your door and watch the kids smoking and drinking.

I live on the corner, and I see it happening—lots of good kids gone bad. They have made the wrong decision.

I first heard about the Massachusetts Governor's Alliance Against Drugs two years ago when Governor Michael Dukakis visited my school. He held a school assembly, and afterward, he met with 20 kids privately and asked them what was happening in our school. I was asked to be part of that small group.

Usually when an adult comes into a classroom, nine out of ten kids find a way to tune him out. But with Governor Dukakis, we really understood his point of view, and he understood how we felt. He showed that the highest person in State Government really cared about us.

After that, I worked with other people in my class and our faculty advisor, Mrs. Raftery, to start a SADD, Students Against Drunk Driving, chapter in our school.

Last year, I took about 20 hours of training on how to become a drug and alcohol peer leader and peer educator, because I had seen what drugs did to my brother, and I felt strongly that I didn't want the same thing to happen to me or my friends.

The CHAIRMAN. How is your brother doing?

Mr. TORRES. My brother is doing very well. He has stopped using drugs, and he has disassociated himself with those people.

The CHAIRMAN. Very good.

Mr. TORRES. This year I have expanded my training to include AIDS education, and I spend a lot of time working with the fourth and fifth-graders.

We as peer leaders teach kids how to make the proper decisions. If we teach them how to make a decision, then maybe the kids will decide to say no to drugs.

Straight talk from another kid is usually put in such a way that the younger kids will understand you and relate to what you are saying. Adults just never seem to have the same impact to convince younger kids about the dangers of drugs and alcohol that we have.

In the last few years, our school has been cleaned up. We intervene in the halls, in lunchrooms, and try to help other kids. There is a better positive awareness about drugs, and kids are learning the facts. Drug use has been slowly decreasing since I was a freshman. More kids are taking an active part in SADD. This year, our SADD chapter has doubled. We have matured. As we get older, kids smarten up. Older kids are aware of the need to help freshmen.

We know we can always send kids to Mrs. Raftery for help, because she is someone they trust. Sometimes, kids won't listen, and we can't reach them. Unfortunately, some of them have to hit rock bottom.

Our peer leadership program just started three years ago, but we have made a lot of strides since then. Mrs. Raftery is the influence, and we carry out the tasks. We have made an influence on others.

All high schools should have well-trained peer leaders who help educate and dispel myths that young kids have about drugs and alcohol. Alcohol is still the biggest problem, because every weekend kids want to get "wasted". Someone will always buy it for you—or, they can always take a quick trip to New Hampshire, because it is easier to get there.

Being part of this peer education program has helped me understand more about other people. I can use my training not just with kids, but with adults. The best tool anyone can give us is good education. We can't stop drugs from being in our society, but we can educate kids not to use them.

As testimony to that fact, we received a letter recently from a young kid in fifth grade, stating he was thankful for our taking time out to go in and talk to him on proper decisionmaking and drug and alcohol abuse. He wrote each member of our peer leadership group a little note. He told me to let my other friend talk more. He told one girl that he loved her acting; another, that no matter how short she was, he still accepted her; and also, he told another girl he loved the color purple because she was wearing it. But one girl, he told to talk more. And the biggest influence on one of my co-peer leaders was this kid told him he loved him as a friend.

I think with that letter, we understood that we did reach somebody.

We have kids eager to join our peer leadership program for next year, and hopefully, we will have the funding to have it started again.

Thank you.

The CHAIRMAN. Thank you. Those were excellent comments, and you deserve a lot of credit for your initiative and what you are doing.

Tell me, in the peer program, you took a few hours of training, I understand, about 20 hours of training?

Mr. TORRES. Yes, sir.

The CHAIRMAN. Can you tell us a little bit about what that is like?

Mr. TORRES. Well, every week for about two months we stayed after school for two hours with a woman from the Medical Foundation in Boston; and also, our advisor was there, learning at the same time. It was either skills on learning how to be a good listener—but not learning how to give advice, because that's the worst thing to do—but becoming a listener, becoming a friend, a helper; and also on the proper way to make a decision, and refusal skills.

And joining the peer leadership program helped me not just with learning about drugs and alcohol, but I became friends with more kids. And with the whole network that we have, that's what our program is called—it is called "Friends." We just went to a conference on June 3rd, and that was the whole topic, was friends.

The CHAIRMAN. Is Mrs. Raftery here?

Mr. TORRES. Yes, she is.

The CHAIRMAN. Would she stand, please?

Mrs. Raftery, we want to acknowledge your presence here and the very fine work that you have obviously been involved in. You deserve a lot of credit, too.

Mrs. RAFTERY. Thank you, Senator.

The CHAIRMAN. Tell us, Freddy, how do you work with the classmates to help them?

Mr. TORRES. Well, when we decide to go to a school, we all divide up the work. One person will take one topic or another, and we each share an equal amount of time of how we split it up. And when we go into the classrooms, we go in on a first-name basis, and we tell the kids a little bit about ourselves and why we joined the program. And we tell the kids to feel free to ask us any questions, whether personal or not.

One kid asked us one day whether or not we had in the past tried or used drugs. We each answered yes, because either we have had a drink, or we have been pressured into smoking, and one girl even stated that, yes, she tried marijuana, she was involved with it, and it ruined her relationship with her mother; but now she joined peer leadership, and that was the cause of it, because she wanted to get off of drugs.

The CHAIRMAN. I notice you mentioned the work you did with fourth and fifth-graders. What did you do with them?

Mr. TORRES. We went to their schools twice. The first time, we did decisionmaking. When we went into that classroom, we did two skits on stealing. One was a positive, and one was a negative. We showed them that, and afterward, we asked if there were any volunteers. Just about every kid raised his hand, and we divided them up into groups of three or four kids to do their skits, and we let them make up their own lines.

The second time we were there, we asked them whether or not they wanted to talk about drugs and alcohol, and there was a very big affirmative answer. We went there, we brought information, we showed them movies, we showed them how to do skits about it, and we even played a baseball game with questions about drugs and alcohol, the singles being the easiest questions and the home run the hardest; if they got the answer wrong, we provided the answer for them, with the explanations. So the kids are really involved, and they learn something from being involved.

The CHAIRMAN. Who are your other associates? Are they from your high school, too, or are they from other schools?

Mr. TORRES. No. They are from my high school.

The CHAIRMAN. How many do you have in the program?

Mr. TORRES. Last year when we started, there were eight of us, and this year there were six, because two had graduated.

The CHAIRMAN. And you are hopeful to keep the program going, is that correct?

Mr. TORRES. Yes, we are.

The CHAIRMAN. Very good. Okay. That is very impressive, and we are glad to get your testimony.

Mr. Hedrick.

Mr. HEDRICK. Thank you, Mr. Chairman.

I am testifying for the thousands of communications professionals who make up this unprecedented volunteer private sector coalition.

Our objective is to reduce consumer demand for illegal drugs, while utilizing the combined creative talents of the advertising industry and the communication force the media of America to fundamentally reshape social attitudes towards illegal drugs, their use and their users.

Quite simply put, our aim is to un-sell illegal drugs.

We believe that marketing has a very unique role to play in responding to this crisis. First, we must recognize we are competing for consumer share, in our case, non-users, against literally the largest and most profitable business of the world. This business uses enormously sophisticated marketing techniques in segmentation, sampling, distribution, and line extensions.

Secondly, we must recognize that the problem is tragically and uniquely self-inflicted. No one chooses to get cancer. No one chooses to be homeless or poor. But we literally choose—our kids, our friends, our coworkers choose to buy and use illegal drugs. It is not unlike a traditional buying decision for any product or service.

Third, we recognize the issue isn't awareness; it is attitudes. Illegal drugs are perceived as attractive, their users considered popular or at least acceptable to a significant proportion of the population. Illegal drug use is, unfortunately, part of the social fabric of this country. We cannot legislate changes in these attitudes. They must be reshaped over time.

Fourth, if you apply what we call the lowest range of traditional advertising-to-sales ratios in competing with the $150 billion a year industry of illegal drugs, you find the rationale for our $500 million annual media objective over the next three to four years.

Our strategy is to de-normalize illegal drugs by creating social intolerance of any use. This strategy was developed over 18 months by a Research and Strategy Task Force made up of the top marketing, advertising and drug research experts in the country, including the National Institute on Drug Abuse, Office of Substance Abuse Prevention, University of Michigan Social Research Institute, New York State Division of Substance Abuse Services, and Phoenix House Treatment Foundation, to name a few.

Our primary focus is to reduce the number of people trying illegal drugs for the first time and to reduce occasional non-addicted use. Now, to affect those millions of decisions being made every day, in every city and town in this country, we must communicate both with the consumers making those decisions and with the people who are influencing those decisions and societal attitudes at large.

Demographically, this breaks down to a separate focus for preteens, teens, young adults, along with peer groups, parents, health care professionals, and opinion leaders.

Beyond demographic specificity, the strategy shows we must address illegal drugs specifically and separately, because reasons for use vary dramatically by drug and by situation when used.

The research strategy also found that we can develop no one advertising them or no one spokesperson that can effectively accomplish the de-normalization objective across all targets and for all drugs. The problem is too broad and longstanding, and the issues are much too varied.

Rather, we have developed a series of primary consumer and influencer message areas that you will see in just a few moments in the actual creative work.

Over the past 15 months, 60 agencies have produced truly compelling and interpersonal communication. Each agency volunteers to work on a specific target group and a specific drug, based on their own expertise and their own interest. Their own research goes far beyond what we provide them, including work with volunteer drug experts from around the country.

All work is reviewed in both rough and finished form by a committee of the very top advertising and creative executives and drug experts. And all production costs more than $20 million in value to date have been absorbed by the producing agencies and their production partners and craft and talent unions.

We launched this program in April of 1987. We currently have 35 television commercials, 25 radio commercials, and more than 80 magazine and newspaper print ads.

The quality of the work along with the urgency of the problem have been the primary reason that our initial media support has been so encouraging. Our best estimate for a total first-year media figure is $150 million in totally volunteered time and space, much in prime time, and full-page ads in major magazines and newspapers. This includes all three television networks, 13 cable networks, 13 radio networks, every major magazine publishing company, more than 3,500 newspapers, and over 130 health care professional journals.

Beyond this, the advertising has had significant use in corporations as part of employee education programs and in many school and community prevention programs.

We are monitoring and evaluating this program using our own attitudinal research program, which is the largest and most comprehensive attitudinal research ever conducted, tracking more than 35,000 people over four years. The base wave was conducted in March of 1987, and we now have very preliminary top-line results from our first 1988 tracking wave.

Many critical attitudes have already started to shift over the past year; they are all consistent and positive in every demographic segment. These include a more negative perception of users and a more positive view of non-users; significant increases in the perceived risks of using marijuana, cocaine, and "crack"; and stronger recognition of impact and influence on children. siblings and peers. These are precisely the kinds of attitudinal changes that must precede any meaningful reduction in the behavior of use over time.

Looking forward to the future, we have two primary objectives over the next year. First, we are working to increase our current media support significantly closer to the $500 million objective. Our momentum in this area continues to build literally month after month after month for every medium, particularly television.

Second, we are developing more advertising targeted to preteens and parents, along with Hispanic and black specific advertising.

I believe that this is just the beginning, not just for our coalition but for others. Advertising is really only one part of the long-term solution, but I think we are a very important example of what is being done and can be done in the private sector.

I think this issue demands our best thinking, our best skills and, quite frankly, our passion. There is simply no acceptable alternative. You can't pay people to bring the kind of top-level commitment that this unprecedented coalition has had and will continue to have to the dream of a drug-free America.

If I can, I would like to show you some examples.

[Chart.]

Mr. HEDRICK. The first ad is targeted to teen girls: "What to Do if He Hands You a Line." Research suggests that the significant majority of teen girls are exposed to cocaine first in the dating situation.

The CHAIRMAN. Are you going to go through all of the charts?

Mr. HEDRICK. Yes. There are six of them.

[Chart.]

Mr. HEDRICK. "Cocaine Lies." This is a series of all-copy ads directed to the myths.

[Chart.]

Mr. HEDRICK. "Cocaine." This is self-explanatory.

[Chart.]

Mr. HEDRICK. "If You're Into Dope, You Might As Well Smoke This." We have taken no point of view on drug-testing. We think it is an interesting point of information, though, for college students to know that more and more companies are doing pre-employment drug-testing and put a lot of hard work and money at risk.

[Chart.]

Mr. HEDRICK. "You're Looking at a Cocaine User Giving her Baby a Fix." This addresses a general audience against the perception that "Drug use is not my problem."

[Chart.]

Mr. HEDRICK. "What is Your Child Taking in School This Year?" The importance of the influence of parents should not be under-estimated.

[Chart.]

Mr. HEDRICK. The classic: "If Everybody Says it Can't Happen to Their Kids, Then Whose Kids is it Happening to?"

[Chart.]

Mr. HEDRICK. "He's the Image of His Father." If parents stop, kids won't start.

[Chart.]

Mr. HEDRICK. This is one of a series targeted at corporate executives, getting them to develop employee education programs: "Only a Few People Can Help a Drug Addict. Unfortunately, You're One of Them." Targeted to run in the Wall Street Journal and similar business publications, it refers callers to the National Institute on Drug Abuse Workplace Help Line.

[Chart.]

Mr. HEDRICK. Lastly, one of a series of 35 developed to specific targeted groups of health care professionals, this one to ob-gyn. "How Many New Drug Addicts have You Delivered?"

We also have similar ads directed at pediatricians, psychiatrists, dentists and nurses.

And now some examples of some recent television ads.

[The following videotapes were shown: 1. "Pool Party", 2. "Grave Words", 3. "Nose", 4. "Circles", 5. "Housewife", 6. "Catching Up To Her", 7. "Girl and Dealer".]

Mr. **Hedrick**. Thank you, Mr. Chairman.

[The prepared statement of Mr. Hedrick follows:]

The Media–Advertising Partnership for a Drug-Free America
In Cooperation with the Ad Council

UNITED STATES SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

TESTIMONY AT THE HEARING ON PREVENTION AND TREATMENT OF DRUG ABUSE

THOMAS A. HEDRICK, JR.
EXECUTIVE DIRECTOR

JUNE 16, 1988
WASHINGTON, D.C.

c/o American Association of Advertising Agencies
666 Third Avenue, New York, N.Y. 10017 (212) 682-2500

Mr. Chairman, members of the committee, ladies and gentlemen. My name is Thomas Hedrick, and I am Executive Director of The Media-Advertising Partnership for a Drug-Free America. I am testifying for the thousands of communications professionals who make up this unprecedented, volunteer, private sector coalition.

Our combined expertise includes America's advertising agencies, national and local media, marketing research, talent unions, broadcast teamsters unions, print production unions, national advertisers, drug and drug research experts, and thousands of individual professionals in communities across the nation who volunteer their time to coordinate this initiative in their local communities. We are guided by a Management Board whose executive committee includes Herbert Baum, President of Campbell Soup, Daniel Burke, President of Capital Cities/ABC, Richard McLoughlin, President of Reader's Digest, Louis Hagopian, Chairman of N W Ayer Advertising, Allen Rosenshine CEO of the Omnicom Group of Agencies and Leonard Matthews, President of the American Association of Advertising Agencies.

Our objective is to reduce consumer demand for illegal drugs, by utilizing the combined creative talents of the advertising industry and the communication force of the media of America to fundamentally reshape social attitudes towards illegal drugs, their use, and their users. Our aim is to unsell illegal drugs.

We believe our marketing, media, and advertising expertise has a unique role to play in responding to the crisis of illegal drugs.

This is true, first, because we recognize that we are competing for consumer share, in our case non-users, against the largest and most profitable business in the world. The business of illegal drugs uses enormously sophisticated marketing techniques in segmentation, sampling, distribution, and line extensions.

Second, we recognize that the problem is tragically and uniquely self-inflicted. No one chooses to get cancer. No one chooses to be homeless or poor. But we choose -- our kids, friends, co-workers -- choose to buy and use illegal drugs. It is not unlike a traditional buying decision for any product or service.

Third, recognize the issue isn't awareness, it's attitudes. Illegal drugs are perceived as attractive, their users considered popular or at least acceptable to a significant proportion of the population. Illegal drug use is part of the social fabric of this country. We cannot legislate changes in these attitudes -- they must be reshaped over time.

Fourth, if you apply even the lowest range of traditional advertising to sales ratios in competing with the $110 billion a year industry of illegal drugs, you find the rationale for our $500 million annual media objective over the next three to four years.

Our strategy is to "denormalize" illegal drugs by creating social intolerance of any use.

This strategy was developed during 1986 by a Research and Strategy Task Force made up of the top marketing, advertising and drug research experts in the country; including the National Institute on Drug Abuse, Office of Substance Abuse Prevention, University of Michigan Social Research Institute, New York State Division of Substance Abuse Services, and Phoenix House Treatment Foundation.

Our primary focus is to reduce the number of people trying illegal drugs for the first time, and to reduce occasional, non-addicted use. To affect those millions of decisions being made every day in every city and town in this country, we must communicate with the consumers making those decisions, and with the people influencing those decisions and societal attitudes at large. Demographically, this breaks down to a separate focus for preteens, teens, and young adults, along with peer groups, parents, healthcare professionals, and opinion leaders.

Beyond demographic specificity, the strategy shows we must address the illegal drugs specifically and separately, because reasons for use vary dramatically by drug and situation when used.

The strategy research also found that no one advertising theme or spokesperson could effectively accomplish the "de-normalization" objective across all targets and for all drugs. The problem is too broad and long-standing, and the issues are too varied. Rather, we have developed a series of primary consumer and influencer message areas, that you will see later in the actual creative work.

Over the past ~~eighteen~~ 15 months, ~~fifty-eight~~ 60 advertising agencies have produced truly compelling interpersonal advertising communication. Each agency volunteers to work on a specific target group and drug based on their own expertise and interest. Their own research goes even beyond what we provide them, including work with volunteer drug experts around the country.

All work is reviewed in both rough and finished form by a committee of the very top advertising creative executives and drug experts. All production costs, more than $20 million in value to date, are absorbed by the producing agencies and their production partners and craft and talent unions.

This program was launched in April 1987. We currently have thirty-two (32) television commercials, twenty-five (25) radio commercials and more than eighty (80) magazine and newspaper print ads. The advertising already has high awareness that has been widely recognized by the public, drug experts, national awareness surveys, and major creative awards groups.

The quality of this work, along with the urgency of the problem, have been the primary reasons that our initial media support has been so encouraging. Our best estimate for a total first year media figure is $150 million, in totally volunteered media time and space, much in prime time and full-page ads in major magazines and newspapers. This includes all three television networks, thirteen cable networks, thirteen radio networks, every major magazine publishing company, more than 3,000 newspapers and over 130 healthcare professional journals.

Beyond this, the advertising has had significant use in corporations as part of employee education programs, and in many school and community prevention programs.

We are monitoring and evaluating this program using our Attitudinal Research Program, the largest and most comprehensive attitudinal research ever conducted, tracking more than 35,000 people over four years. The base wave was conducted in March, 1987, and we now have very preliminary, top-line results from our first 1988 Tracking Wave. Many critical attitudes have shifted over the past year, and they are consistent and positive in all demographic segments. These include a more negative perception of users and a more positive view of non-users, significant increases in the perceived risks of using marijuana, cocaine and crack, and stronger recognition of impact and influence on children, siblings and peers. These are the kinds of attitudinal changes that must precede any meaningful reduction in the breadth of use over time.

We have two primary objectives for 1988/89. First, we are working to increase our current media support significantly closer to the $500 million objective. Our momentum in this area continues to build month, after month, after month for every medium - - particularly television. Second, we are developing more advertising targeted to preteens and parents, along with hispanic and black specific advertising.

This is just the beginning. Americans can curb their appetite for illegal drugs if they are persuaded the costs outweigh the benefits. Advertising is only one part of the long-term solution, that must also include better information, basic education, treatment, and primary research. We are an example of what's being done in the private sector. This demands our best thinking, our best skills, and our passion, There is simply no acceptable alternative. And you can't pay people to bring the kind of top level commitment that this unprecedented coalition has had and will continue to have, to the dream of a Drug-Free America.

I would like to show you some examples of our more recent print and broadcast advertising.

PRINT

1. "WHAT TO DO IF HE HANDS YOU A LINE"
2. "COCAINE LIES"

3. "COCAINE-GUN"

4. "IF YOU'RE INTO DOPE, YOU MIGHT AS WELL SMOKE THIS"

5. "YOU'RE LOOKING AT A COCAINE USER GIVING HER BABY A FIX"

6. "WHAT IS YOUR CHILD TAKING IN SCHOOL THIS YEAR?"

7. "IF EVERYBODY SAYS IT CAN'T HAPPEN TO THEIR KIDS, THEN WHOSE KIDS IS IT HAPPENING TO?"

8. "HE'S THE IMAGE OF HIS FATHER"

9. "ONLY A FEW PEOPLE CAN HELP A DRUG ADDICT. UNFORTUNATELY, YOU'RE ONE OF THEM"

10. "HOW MANY NEW DRUG ADDICTS HAVE YOU DELIVERED"

TELEVISION

1. "POOL PARTY" :30; Backer Spielvogel Bates; Target - Preteens

2. "GRAVE WORDS" :30; BBDO; Target - Parents

3. "NOSE" :30; Saatchi & Saatchi DFS Compton; Target - Teens

4. "CIRCLES" :30; Saatchi & Saatchi DFS Compton; Target - Young Adults

5. "HOUSEWIFE" :30; Backer Spielvogel Bates; Target - Young Adults

6. "CATCHING UP TO HER" :30; Leo Burnett; Target - Teens/Peers

7. "GIRL & DEALER" :30; Ogilvy & Mather; Target - Teens

8. "EXPERIMENT" :30; N W Ayer; Target - Teens

The **Chairman**. Those are very powerful messages. Let me ask you, what has been your success in getting these on prime time, or important viewing time?

Mr. **Hedrick**. We have had, I think, phenomenal success, particularly for such a new program. We only have the specific data for one network, Capital Cities ABC; of $31 million in time value they have given us, over 55 percent has been in prime time, and in an evaluation of the larger metropolitan areas, we find that we are getting somewhere between 15 to 25 percent in prime time, which is precisely the mix that you would want for any sophisticated marketing program.

The issue, I think, Senator, is that we need to get even more of it more often over time.

The **Chairman**. We had funding for education programs in the AIDS bill that we passed in the Senate. Do you think we ought to have a component in terms of funding to be able to purchase valuable time in terms of these kinds of programs?

Mr. **Hedrick**. I really don't think it is going to be necessary, Senator. I think if what the Advertising Council has been doing over the past five years on top of what we have done over the past 15 months had not been so successful, and if we hadn't seen the momentum from the private sector continue to build, then I think we might have needed that, but I really don't think that will be necessary.

The **Chairman**. What information do you have as to the success of de-selling substances?

Mr. **Hedrick**. Well, we are going to leave it to the National Institute on Drug Abuse and to Lloyd Johnston, who is going to speak later, to track the usage. What we are trying to do is affect the attitudes that drive the behavior, attitudes specifically like perceptions of drug users as popular.

On a base wave, we know that 39 percent of kids 9 to 12, a representative sample across the United States view drug users as popular. That is an attitude, a perception that has to change. For example, in the first tracking wave, that is now down to 31 percent.

It isn't going to happen, I think, as you pointed out earlier, over the short term. This is something we have got to keep our minds on and our sleeves rolled up for the longer term. But I think it can affect those attitudes that drive behavior.

The **Chairman**. Well, I want to commend you. This is enormously resourceful, and I think these are just enormously powerful ads. We would be very interested if you would keep us informed about how the program is moving and going, and whether you have suggestions about what we might do to be of help.

Mr. **Hedrick**. I think the only one we have is something that was talked about earlier—working more together. We are working with the Office of Substance Abuse Prevention and with the largest local community prevention programs—the Parents Resource Institute for Drug Education, the National Federation of Parents for a Drug-Free Youth, all of whom have very strong local community programs. We would be happy to be a resource and work together with any of those organizations.

The **Chairman**. Thanks an awful lot.

Mr. **Hedrick**. Thank you.

The CHAIRMAN. And I want to thank you again, Mr. Torres, very much. It has been very good to see you. We appreciate your coming down here, and we'll look forward to seeing you back home.

Mr. TORRES. Thank you, sir.

The CHAIRMAN. Very good.

Our next panel consists of three experts who will testify about education programs. Dr. Lloyd Johnston was on the Advisory Council, National Institute of Drug Abuse, from 1982 to 1986, where he chaired the Subcommittee on Prevention. Currently, Dr. Johnston directs the Institute for Social Research at the University of Michigan and will report on recent findings on patterns of drug use.

Glenn Levant is the Commanding Officer of the Bureau of Special Investigations of the Los Angeles Police Department. He will tell us about the DARE Program created in Los Angeles and implemented in many States across the country.

And then we welcome Mary Lou Bozich, an educational specialist for Substance Abuse Prevention with the Utah State Office of Education, who is here to tell us about the education program conducted in elementary and secondary schools.

We will start off with Dr. Johnston.

STATEMENT OF DR. LLOYD JOHNSTON, PROGRAM DIRECTOR, INSTITUTE FOR SOCIAL RESEARCH, UNIVERSITY OF MICHIGAN, ANN ARBOR, MI; DEPUTY CHIEF GLENN LEVANT, BUREAU OF SPECIAL INVESTIGATIONS, LOS ANGELES POLICE DEPARTMENT, LOS ANGELES, CA; AND MARY LOU BOZICH, EDUCATIONAL SPECIALIST FOR SUBSTANCE ABUSE PREVENTION, UTAH STATE OFFICE OF EDUCATION, SALT LAKE CITY, UT

Dr. JOHNSTON. My name is Lloyd Johnston, and along with my colleagues I have for the past 20 years directed some 15 national surveys of drug use among young Americans of high school/college age as well as of those in their twenties. The main series has been the National High School Senior Surveys, which are going on today—in fact, there is one underway this spring.

I have been asked to talk about the nature of America's drug epidemic and where we are in it. In the very short time available, I can only give you a thumbnail sketch. Most of it, I think, is familiar to you.

The epidemic we are currently experiencing originated in the late Sixties, as drug use broke out from small and relatively marginal segments of the population and became, in fact, a majority behavior among our young people.

The acceleration of the epidemic was largely fed by the frustrations of the Vietnam War and of Watergate which gave rise to a period of great youthful alienation, in which drug use took on symbolic meaning and was a form of political and social protest for many young people. As a result a set of norms evolved which were quite different than our historical norms among young people regarding drugs.

The epidemic, of course, has changed character over the years as various drugs have come and gone, but in fact, the overall proportion of young people who use illicit drugs reached the peak around 1980, and in the years since has actually been declining gradually.

There have been some important improvements in particular drugs. Marijuana is one where we have seen a considerable decline in active use, and also in heavy use, in the last eight years or so. LSD, PCP, tranquilizers, amphetamines, sedatives and heroin, all have shown improvement, sometimes substantial improvement.

Cocaine, of course, has been the most recent and the most troublesome element in this epidemic. Actually, the great increase in prevalence in cocaine use among adolescents and young adults occurred in the late Seventies. We reached what was more or less a peak prevalence level in 1980, and then remained at that level through 1986, despite increasing efforts on the part of all levels of Government to suppress the cocaine problem.

However, there has been a qualitative shift in the nature of cocaine use, as you well know. In the last several years, with the advent of "crack", even though maybe no more people are using cocaine, the forms that they were using became more dangerous.

And finally in 1987, we saw for the first time an improvement even in the cocaine situation, with the decline in use among high school students, college students and young adults in their twenties.

I should mention all of these populations are based on youngsters who finish school, about 85 percent of an age group. We, of course, don't have the out-of-school population, and as one of your colleagues mentioned, this is a particularly at-risk group. I think a lot of the "crack" epidemic is concentrated in that group and particularly in large inner-city areas.

Now, the improvements that we have seen in the case of marijuana and more recently, in cocaine, clearly cannot be explained by reduced supply—and supply reduction has been our major national strategy for dealing with drugs—because marijuana has remained virtually universally available to young people this age throughout the period, according to their own reports. Cocaine has actually been increasing in availability for the last eight or ten years, including in 1987, when we saw the downturn in use.

I might mention that DEA figures tell the same basic story about the availability of cocaine.

Therefore, really, I think what has happened here is that there has been some reduction in demand—substantial in the case of marijuana; so far modest in the case of cocaine. And I think the major determinant of that change has been that there has been a change in the perceived risks of these drugs. There has been a large change in the perceived risks of being a regular marijuana user, and I think that explained the large drop in the number who are heavy users of that drug.

Only in 1987 did we start to see a turnaround in the perceived risks of cocaine among these populations, at least in terms of experimental usage. In earlier years, people came to see heavy cocaine use as dangerous, but most people don't think of themselves at that level of use. When they finally saw experimental use as more dangerous, we started to see a turnaround in the situation. It won't surprise me if we see a continuation in 1988.

With the change in perceived risk, I think, has generally come a change in disapproval or peer norms. So in a way, a kind of public health model may help to explain how young people view drugs and respond to them.

What caused the change in perceived risks? I think it has been a combination of things. I think the media have played an important role. I think schools and families have been important; and to some degree, I think vicarious learning has been important, where youngsters saw their own friends, or the friends of their older siblings, who got into trouble with drugs, and they then decided they didn't want that for themselves. In a sense, some of those videos we saw earlier are based on a kind of vicarious learning.

But the long and the short of it is that supply reduction, in my opinion, has not worked despite massive and increasing resource investments being put into that strategy; and demand reduction has shown considerable promise, despite very meager investments in that strategy.

So the most important thing I have to say to you and the Congress is that it is critical for us to start shifting the balance of attention and resources in the direction of demand reduction strategies. Ever-larger allocations on the supply reduction side are, in my opinion, doomed to failure: because there will be an almost endless supply of suppliers—and I would be glad to talk about that more if you'd like. With that failure, I think, will come an ever-increasing sense of national frustration and a willingness to consider radical solutions, from legalizing drugs to yielding precious Constitutional freedoms.

Proper attention, on the other hand, to the demand reduction strategy could, in my opinion, pay off handsomely in reducing drug use within a three- to five-year timespan. Further, changing attitudes, beliefs and norms, should prove the most durable type of solution, for it does not depend on the continued monitoring of people's behavior as do the various coercive techniques.

I have in my written testimony a number of specific recommendations that I offer to you, the first of which is that we need to mobilize every community in the country and establish a leadership group of community leaders in every community. That is happening in a few cities, and I think it is very promising in those where it is happening; but I think it has to happen more broadly, and I want to point out that I think there is a level of voluntarism on the part of the American people—a willingness to sacrifice time, money and energy to help deal with this problem—which if properly drawn upon is probably the most important resource that we have available for dealing with the problem.

I also think it is critical that we continue to expand our knowledge base of prevention techniques. I think the level of effort there has really been very meager, considering the importance of the problem. Specifically, I recommend the development of several "think tanks" or prevention development centers, which would get a lot more ideas on the table for consideration. I think we are well past the point where anyone believes there is a single silver bullet to solve the problem; we need a multifaceted strategy, and we need more ideas cooking. And I think important among them is how to engage youngsters in the solution of the problem themselves.

We also need a lot more evaluation research on those new ideas. We have not been investing much in that, and we really need a better knowledge base.

I think we need to encourage the kind of media advertising effort that was just described by Mr. Hedricks: I think it is a splendid effort. Our own data suggest that it appears to be working quite well.

I think we also need certain epidemiological methods that we don't yet have available. In fact, we need more emphasis on science, generally. The knowledge base seems to get left out of many of these discussions, and I don't mean specifically in this Committee, but in other discussions that I hear at the national level.

And finally, several people have mentioned the importance of alcohol and cigarettes. I too think we really need to stop those who legally and massively extol the virtues of drug use in our society. These two industries each do so on a multibillion dollar per year basis, overshadowing our total societal expenditures on all forms of drug, alcohol, or cigarette prevention programs. The distinctions between licit and illicit drugs may be clearer to those of us who are older adults, but I think some of the distinctions get lost to youngsters. As a society we give a mixed message to our kids about drugs.

I'll stop there, Mr. Chairman, and be glad to answer any questions.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Johnston with an attachment and response to questions submitted by Senator Hatch follow:]

TESTIMONY OF

LLOYD D. JOHNSTON, PH.D.

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THE UNIVERSITY OF MICHIGAN
ANN ARBOR, MICHIGAN

BEFORE THE

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

IN

HEARINGS ON
DRUG ABUSE AND DRUG ABUSE PREVENTION

JUNE 16, 1988

Despite the improvements the numbers still remain impressive, with nearly 60% of American high school graduates having tried an illicit drug by the end of high school and nearly 80% among those now in their late twenties. With regard to cocaine, roughly 15% have tried it by the end of high school, but this rises to nearly 40% among those in their late twenties.

I should also note that over the 13 years of the study there has been little change in the proportion of students who think they can get marijuana, if they want some (despite an appreciable drop in use); and for cocaine, perceived availability has risen steadily in the 80's, with the highest level of availability reported in 1987 (the most recent survey). (DEA figures on the price and purity of cocaine available on the streets of America tell much the same story.)

What I think is most relevant from our recent survey findings, for the purposes of the deliberations before the Congress, is first that despite greatly increased efforts to stem the supply of drugs over the past 8 to 10 years, we have in the main failed; and, secondly, that despite the resulting sustained or increasing availability which has occurred; for most drugs, we have seen a reduction in use among high school students and young adults, including cocaine use in 1987.*

The long and the short of it is that supply reduction has not worked, despite massive resource investments, and demand reduction has shown considerable promise, despite very meager investments. In my opinion, the most important thing that I have to say to the Congress on this issue is that it is critical for us to start shifting the balance in attention and resources in the direction of demand reduction strategies. Ever larger allocations on the supply reduction side are, in my opinion, doomed to failure (for

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*I should point out that we do not cover the high school dropouts in this survey series, because it starts at the end of senior year, and clearly this is a more "at risk" segment of the population. Nevertheless, we have been covering quite accurately, I believe, the roughly 85% who do finish high school (according to Census figures). For the dropouts, the problem is clearly more serious--particularly with regard to crack, I suspect--but no one knows for sure just how much more serious.

Mr. Chairman and other distinguished members of the Committee, I appreciate having this chance to discuss with you the urgent national issues of drug abuse and drug abuse prevention. My name is Lloyd Johnston. I am a Program Director and Research Scientist at the University of Michigan's Institute for Social Research, where, since the late sixties I have conducted some fifteen national surveys of drug use among American adolescents and young adults. Since 1975 I have directed (along with colleagues Jerald Bachman and Patrick O'Malley) what has become known as the annual High School Senior Survey. (See Johnston, 1988, and Johnston, O'Malley, and Bachman, 1987.) In the policy arena, I currently serve as a Presidentially-appointed Conferee to the White House Conference for a Drug Free America, and previously served as a member of the National Advisory Council on Drug Abuse (1982-1986), where I chaired its Subcommittee on Prevention (1983-1986).

My limited time does not permit a very detailed description of the drug epidemic, nor an analysis of causes. By way of a thumbnail sketch, I can tell you that the proportion of young Americans involved in the use of illicit drugs peaked around 1980 and has been declining gradually since. The proportions using most of the individual classes of drugs, such as marijuana, LSD, stimulants, sedatives, and so on, have also declined, although these drugs differ considerably one from another in their patterns of change. The very large fly in the ointment, of course, has been cocaine, which resisted increasing national efforts since 1980 to control its use. Use of cocaine among adolescents and young adults reached peak prevalence levels in 1980, remained at peak levels through 1986; but, as we all know, the forms of use became more dangerous, largely as the result of crack use (Johnston, O'Malley, and Bachman, 1987; Johnston, 1988a). It was only in 1987 that we saw evidence of some improvement in the cocaine situation, with a significant downturn registered among American high school students, college students, and young adults in their twenties (who were high school graduates).

reasons laid out elsewhere, see Johnston, 1988b)--and with that failure will come an ever-increasing sense of national frustration and a willingness to consider radical solutions, ranging from legalizing drugs to yielding precious Constitutional freedoms. Proper attention to the demand-reduction strategy could, in my opinion, pay off handsomely in reducing drug use within a three- to five-year time span. Further, by changing attitudes, beliefs, and national norms, it should prove the most durable type of solution, for it does not depend on the continued monitoring of people's behavior, as do coercive techniques.

How do I think we can do it? Well, I think it will take some strong leadership, some considerable improvement in our resource allocation, a lot of creativity, importantly some patience, and finally some trust in the spirit and resolve of the American people. As for leadership, I believe the next President must exert personal and continuing leadership on this issue and should have a cabinet level officer to advise him and to help to carry out an integrated policy.* As for resource allocation, I think we should stop pouring ever more resources into the hopeless cause of controlling supply, and redirect any incremental resources primarily toward demand reduction. (This will require real leadership, too, for demand reduction is not the more glamorous, just the more effective way to go.)

Creativity is needed to make up for all of the time that has been wasted over the past 20 years by our not vigorously developing new prevention approaches and systematically evaluating them. Had we been doing that properly over the first few years, we already would have a formidable armamentarium of effective methods in my opinion.

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*I recognize the danger of proliferating roles in the cabinet, and think it could be perfectly appropriate for this new one to have an eight- or ten-year sunshine law attached to it.

The patience is needed because the gains will not be rewarded by dramatic events that make a big splash in the media--as do major drug busts and seizures--but rather by gradual and steady improvement in the situation.

Finally, the American people are a critical part of the solution for two reasons. First, the drug-using behaviors and attitudes of some important segments of them, constitute the problems. Second, the large majority have made it clear that they are willing to contribute to help bring about a solution. I think a level of voluntarism almost unprecedented in peace time is there, waiting for leadership and guidance.

Can drug prevention approaches work? I have already indicated that in the aggregate there has been an improvement in the situation, and not one that can be attributed to any reduction in supply. I think there is some pretty compelling evidence (Bachman, et al., 1988; Johnston, et al., 1987; and Johnston, 1985c) that, when people come to see the use of a drug as dangerous, they either refrain from starting its use or desist using it, assuming they are not already highly dependent. It also seems to be the case that as they come to see it as dangerous, they become more disapproving of its use--in other words, social norms change.

Now, drugs differ in how long it takes for these "corrective processes" to set in--partly as a function of how long it takes the adverse consequences to show up. For cigarettes it took 30 to 40 years, for marijuana it was fifteen or so, for cocaine maybe seven or eight. In the case of PCP we saw such a correction in just the course of a couple of years. The massive public attention paid to "crack" and its dangers, particularly in 1986, may have led to the most rapid correction yet. Among high school seniors at least, it appears that use leveled in 1987, despite more widespread availability.

Now I do not want to be seen as saying that there is not a substantial drug problem, since I am the one who has been saying publicly for a number of years that we have the highest rate of illicit drug use among our young people of any country in the industrialized world. We still do. I'm just saying that we can do a lot to effectively deal with the demand for drugs in this country, especially now that we are moving with the tide rather than against it.

I am also not saying that we should surrender our streets to the drug dealers. Obviously we should not. But if we really are serious about solving the problem rather than continually filling, rebuilding, and refilling our jails with a nearly infinite supply of would-be drug dealers, then I think that we had better start getting more serious about demand reduction.

The directions I suggest are the following:

First, I think we need to help mobilize every community in the country. I cannot recall a subject in recent years which has elicited a sense of voluntarism among the American people as this one. This is an invaluable resource waiting for effective leadership and guidance, from the President on down. Every community in the country should have a community leadership group, drawn from all sectors, mobilizing a community response and clearly establishing a broad community norm.* Only a few have that now.

One of the tasks for such a group would be to put in place systems for educating and mobilizing the parents in that community. Another would be to establish task forces aimed at involving and influencing the major sectors. Within media, for example, a local anti-drug media campaign could be developed. The Federal government can play a role by providing start-up funds--perhaps in the form of matching funds--to stimulate the process. Perhaps more important, it needs to make available some models and demonstration programs to provide some guidelines to such community groups, and it should also develop a system of technical assistance and material.

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*Among the sectors which should be included are business, labor, education, media, criminal justice, the relevant professions, local philanthropy, sports, and political leaders.

Second, we need a much more vigorous effort at developing the knowledge base for drug prevention programs in the schools. The Omnibus Drug Bill of 1986 did contain significant funding for school curricula dealing with drugs--approximately $250 million per year--but the knowledge base available to schools for spending that money in a meaningful way is thin. Most high school students do think that their drug abuse curricula had at least some of the intended effects on their attitudes toward drug use (Johnston, 1988b), but clearly they could be far more effective. Research and development on both school-based and community-based prevention efforts should be rapidly accelerated.

Third, I think we should encourage the media and advertising industries to continue the splendid effort that they have undertaken voluntarily to deglamorize drugs. The high school students in our 1987 national survey indicated high rates of exposure to such "drug spots," and most seemed to feel that they had had the desired impact on their own attitudes and inclinations to use (Johnston, 1988b). We should be careful not to undercut the enthusiasm and commitment of these private sector voluntary efforts; therefore, I think any Federal support should go toward helping local communities produce (but not air) their own complementary spots.

Fourth, we should be getting a lot more prevention ideas on the table for serious consideration; and to this end I would suggest the funding of perhaps three national "think tank" Prevention Development Centers, which would actively engage young people, parents, educators, as well as scholars, in a problem-solving mode aimed at suggesting new and promising interventions. Since the dynamics of the phenomenon is likely to be different for the minority youngster in the inner city ghetto than for the white youngster in a wealthy suburb, different interventions are likely to be needed for different populations. In any case, we need to seriously engage youngsters in the solution to these problems, and I would hope such centers would do just that. Their ideas should help to complement those now being developed through the grant mechanism at the ADAMHA Office of Substance Abuse Programs. All ideas so developed should be made widely available to those who choose to pursue them.

My fifth suggestion relates to the new program ideas being developed for schools, families, communities, the media, etc. It is to institute a serious program of evaluation research on the most promising prevention ideas. For all of the years of the drug epidemic we have been devoting a pittance to this most critical component in our knowledge base for dealing with the drug epidemic--on the order of a few million dollars per year. I contend that had we developed a vigorous program of demonstration programs and serious evaluation as recently as five years ago, we would have a lot more effective programs in our armamentarium at present. We must not keep putting it off.

Regarding my own area, of epidemiological research and monitoring of the drug problem, I think it is fair to say that we have more high quality information about the drug problem than about most social problems, and that we should sustain that position by continuing important indicator systems such as the Drug Abuse Warning Network (DAWN), the National Household Surveys on Drug Abuse, and the High School Senior Surveys (which also include college students and young adults).

However, there are some important gaps. Good national data on treatment demand have not existed since NIDA's Client Oriented Data Acquisition Program (CODAP) was scuttled by the advent of the block grant program. Such information is very important for proper policy planning and evaluation, and a replacement system should be developed quickly, particularly in light of the AIDS epidemic. Also a good system for tracking drug use among out-of-school youngsters--particularly in the inner city--has not been developed. To develop a reasonably good one would probably be fairly expensive by social science standards; but very likely justified given the apparent seriousness of the drug problem in those populations.

And in general, I think our programmatic research on the epidemiology of drug use has been overly modest--particularly given the range of different populations in which the problem and its dynamics must be examined. Doubling it would currently cost about another $10 million per year. The one thing I can say from long experience in this country, and in others for whom I have served as an advisor, is that in the absence of good epidemiological data everyone holds to his own conception of what is happening, and that the majority of these turn out to be misconceptions.

In fact, I have observed that the scientific enterprise responsible for developing our knowledge base on drugs, and on policy related issues, tends to get forgotten in discussions such as the current one in the Congress, and (I might add) in the White House Conference.

I recently had the Alice in Wonderland-like experience of returning from the National White House Conference in Washington--where virtually all speakers from all sectors called for a more serious effort to deal with drugs--to learn that the National Institute on Drug Abuse had to reduce all of its outstanding grants this year by 5% in order to be able to fund at least a mere fifth of the new grant proposals judged to be scientifically meritorious. And this strange procedure has been followed in a number of recent years. Somehow it doesn't sound like a terribly serious part of the national effort.

Finally, I believe that if we are to be consistent and maximally effective in dealing with our young people, we need to stop those who legally and massively extol the virtues of drug use in our society--in particular the manufacturers of alcohol and cigarettes. Since I have testified on these issues previously, I refer the Committee to that earlier testimony (Johnston, 1985a, b, and 1986). I realize that these are tough issues to take on politically; but for the sake of our young people I think that you in the Congress need to address them.* Many have said we cannot just proceed with business as usual if we expect to succeed in solving America's drug problem. I would agree and would argue that this applies to the very destructive advertising by these industries, as well.

That concludes my testimony, Mr. Chairman. I would be pleased to answer any questions you or other members of the Committee may have.

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*Many responsible organizations have, after careful deliberation, come out in favor of a ban on all advertising and promotion of tobacco products, including the American Medical Association, the National Advisory Council on Drug Abuse, the American Cancer Society, the American Lung Association, the American Heart Association, Consumers Union, and others.

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ISR

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July 1, 1988

Senator Edward M. Kennedy
Chairman
United States Senate
Committee on Labor and Human Resources
Washington, DC 20510-6300

Dear Senator Kennedy:

I appreciate your giving me the opportunity to testify before your committee during the recent hearings on drugs and drug abuse policy. This is a particularly important issue for the nation at this historical juncture, in part because some of the proposed solutions may be worse than the original problem.

Enclosed you will find my responses to the set of questions submitted in writing after the hearing, and transmitted by you with ~~your letter of June 21~~. Also enclosed is a commissioned paper I recently completed in which I critically review our general policy strategies and alternatives. The one page abstract will give you an overview of its contents. I would be pleased to have this paper entered into the record but did not have an opportunity to suggest it during the few minutes available for testimony.

If I can be of any further help, please do not hesitate to call.

Sincerely,

Lloyd D. Johnston, Ph.D.
Program Director

LDJ:lrv

Enclosure

REDUCING DRUG USE IN AMERICA:
A PERSPECTIVE, A STRATEGY, AND SOME PROMISING APPROACHES

A paper commissioned by the United States Department of Education

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The Institute for Social Research
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April, 1988

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Abstract

The paper begins with a brief overview of the size and nature of the epidemic of illicit drug use observed among American adolescents and young adults over the past two decades. It is argued that the nation's reliance on supply reduction as its primary strategy for controlling drug abuse has been, and will continue to be, in the main unsuccessful. The major alternative strategy, that of demand reduction, has received far less emphasis despite its far greater promise. It is recommended that a substantial shift in emphasis between these two strategies needs to be made.

Within the general strategy of demand reduction, two quite different approaches are distinguished--coercive techniques versus changing beliefs, attitudes, and norms. The risks and benefits of each approach are considered. Primary prevention and early intervention, using non-coercive techniques, are the strategies judged most promising.

There remains, however, the question of how to develop, and further to demonstrate the effectiveness of, many more such techniques. It is argued that there are three essential components to the process--idea generation, program development, and systematic evaluation. New heuristic approaches are needed to expand the process of idea generation, and some are put forward. A much increased emphasis on the rapid and systematic evaluation of the ideas so generated is also strongly recommended.

The two most far-reaching existing approaches to prevention--school-based programs and media-based efforts--are examined. Both coverage and impact, as rated by students, are considered; and recommendations are offered.

Finally, a number of specific ideas for new and expanded approaches to prevention are offered by the author. Among them are the continued emphasis on the real health and other risks associated with various substances, despite criticisms of this approach in recent years; the development of a model for the early creation of parent groups which mirror the peer friendship groupings of their children; the development of recreational alternatives for adolescents to "partying" which is organized around substance use; systematic attempts to change norms among adolescents in regard to drug use; and a serious societal response to the adverse effects of massive and virtually unfettered advertising of alcohol and cigarettes--the two initial "gateway drugs." The beliefs of young people about the drug using behaviors and attitudes of key role-model groups is also examined, and procedures for changing those beliefs are suggested.

Introduction

A meaningful discussion of how to develop more and better techniques for preventing illicit drug use best follows some review of what the nature of the problem is, how it came about, and how the strategies and programs we have adopted for controlling it seem to be working. Following brief sections on these background considerations, some recommendations are offered for improving the *process* by which new ideas for prevention are put forward, refined, and evaluated--since in the end the process is probably more important than any given proposal. Finally, several specific approaches are suggested.

The American Epidemic of Illicit Drug Use

While more detailed epidemiological descriptions are available elsewhere (e.g., Johnston, O'Malley, and Bachman, 1987a; Miller et al. 1983) a broad outline of the contours of the epidemic is useful for setting the stage for a discussion of prevention policy. Illicit drug use in North America reached epidemic proportions in the late 1960's; in the 1970's the epidemic expanded considerably. In the first half of the eighties we have seen the overall epidemic recede considerably, with the notable exception of cocaine. Cocaine use climbed further among adolescents in the eighties, remained at peak levels among young adults in their early twenties, and climbed some among older adults (Clayton, 1986; Johnston, O'Malley, and Bachman, 1987). Only in 1987 did cocaine begin to show any decline in use.

A number of these points are illustrated in Figures 1 through 5. Figures 1 and 2 show the national trends in marijuana use and for other illicit drugs, taken collectively, for high school seniors and lower grade levels. Figures 3 and 4 show the trends on the same drugs in recent years among college students and their age-mates one to four years beyond high school. (All are high school graduates.) Figure 5 shows recent trends in cocaine use for high school seniors and young adults in their twenties who are high school graduates. What it does not show is that, while usage rates remained fairly stable between 1980 and 1986, a particularly dangerous form of ingestion--smoking cocaine--rose appreciably from 1983 to 1986 due to the rapid rise in crack use.

These data, like most of the other data to be presented in this paper, derive from the ongoing series of surveys entitled, Monitoring the Future. This series was begun in 1975 and is conducted by the University of Michigan's Institute for Social Research under research grants from the National Institute on Drug Abuse. (Johnston, O'Malley, and Bachman, 1987). Each year a nationally representative sample of roughly 17,000 high school seniors in about 135 high schools are surveyed in their classrooms using self-administered questionnaires. They report on their use of a wide array of licit and illicit drugs, as well as on a host of related factors. Figures 1 and 2 are based on seniors' retrospective reports of what grade they were in when they first used each drug. Figures 3 and 4 derive from follow-up surveys, conducted annually by mail, of a subsample of the participating seniors in each graduating class--about 1,000 per year per class. (All samples thus omit high school dropouts, whom we know to have higher than average rates of substance use.) The follow-up surveys have high retention rates (still over 70% of the original panel after 10 years), and the data from these are reweighted to correct for the effects of attrition. (See Johnston et al., 1987a). An excellent national sample of about 1,100 college students is encompassed in the follow-up surveys.

The extent to which the drug epidemic penetrated the adolescent population in America has been illustrated by Figures 1 and 2, which show that for seniors lifetime prevalence rates for marijuana have reached over 50% for some years now. (Lifetime prevalence refers to the proportion having used once or more in their lifetime, while annual prevalence refers to the proportion using once or more in the prior twelve months.) As many as 40% of students have tried illicit drugs other than marijuana during high school. Figure 6 shows the degree of penetration among the young adult population in 1987. (Note that these data are not cross-time trends but age group comparisons for a single year.) It shows that roughly 80% of high school graduates in their late twenties have tried an illicit drug.[1] The lifetime prevalence for cocaine reaches 40% for this age group (data not shown).

While the drug epidemic left the confines of our shores early in this twenty-year epidemic to become a global pandemic, other industrialized nations never attained such large proportions of their young people being involved as has the United States. Neither do their current levels of illicit drug use--and in particular cannabis and cocaine use--even begin to approach the levels found in North America today (Johnston and Harrison, 1984; Smart and Murray, 1981).

Within two decades--decades which spanned a very turbulent period in American history--illicit drug use grew from a rare and deviant behavior among American young people to a statistically normative one. The epidemic spread from the nation's campuses, to others in the same age groups, and then down the age spectrum to high school students and eventually to junior high school students.

The spread of the epidemic up the age spectrum was much less dramatic, as older generations held onto their earlier norms; and what change has occurred in older age bands has occurred largely through generational replacement (Miller et al., 1983). This clearly suggests that adolescence is a critical period for the establishment of these drug-using behaviors, much as is true for cigarettes and to a somewhat lesser extent alcohol.

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[1] The adjusted lifetime prevalence takes into account use reported by the individual in earlier surveys which is not reported in the current survey.

At the present time, the age groups having maximum illicit drug use are those in their late teens and early twenties. Cocaine is the only one of the illicit drugs to show a much higher rate of use among those in their twenties versus those in their late teens (Johnston, O'Malley, and Bachman, 1987; O'Malley, Bachman, and Johnston, 1984; Yamaguchi and Kandel, 1984). See also Figure 5.

Cigarette smoking has been shown to be strongly associated with all forms of illicit drug use, and particularly with the use of marijuana (Johnston, 1973; Johnston et al., 1987; Miller et al., 1983), so efforts which are successful at reducing smoking may have the serendipitous secondary effect of reducing illicit drug use. While it is doubtful that all, or even most, of that association is due to the direct causal connection between them, very plausible hypotheses can be generated as to why some of the connection is likely to reflect a causal link (Johnston, 1986). Cigarette smoking among high school seniors dropped by roughly one-third between 1977 and 1981, followed by much slower decline through 1984. Since 1984 there has been no further decrease.

While there have been some long-term consistencies in the drug epidemic, such as the widespread popularity of marijuana and the tendency of young people to go through a certain predictable sequence of drugs before moving into the "harder drugs" (namely the use of cigarettes, alcohol, and then marijuana), the epidemic is also noteworthy for the wide fluctuations in the popularity of particular substances. For example, both PCP and methaqualone showed a rapid increase and then just as rapid a decrease in popularity during the past ten years. Daily marijuana use did much the same, but over a longer period: daily use among high school seniors stood at 6% in 1975, 11% in 1978, and 3% in 1987. Cocaine showed a dramatic increase in popularity late in the epidemic, and is about the only class of illicit drug to resist the decline of the past five or so years. Regardless of which combination of different illicit drugs has been in vogue at a particular time, however, the individual correlates of use have tended to remain pretty much the same (Bachman, O'Malley, and Johnston, 1986).

Many individual risk factors have now been identified--too many to be discussed here--but clearly central among them are poor adjustment in school and a more general pattern of deviant behavior. A low level of religious involvement and spending a lot of time out of the parental home have also been strongly correlated factors. However, shifts in these individual risk factors can hardly account for the wide fluctuations in drug use observed in recent years, since these factors have not fluctuated very much themselves, according to results from the Monitoring the Future studies (Bachman, et al., 1988), and most of them probably cannot be socially manipulated to any great degree in any case. The importance of these facts for our approach to prevention is considerable, since it suggests that gaining a better understanding of individual differences in susceptibility (whether genetic, constitutional, or in personality), is not likely to lead to major solutions to the nation's drug problem. It seems clear that broad cultural and societal factors have led to the epidemic and, therefore, will also be critical to achieving any major reductions in the epidemic.

The causes of the onset and partial retreat of the drug epidemic are surely multiple and complex. While some are hard to prove empirically, the following interpretations are offered. In the sixties Timothy Leary and other proponents of mind expansion, inner-directedness and "dropping out," saw a convergence of their messages with the breaking of the achievement bonds of "the silent 50's." There was a generation ready for the message. Further, social control by the family of children and adolescents was being eroded as divorce rates increased and a much larger proportion of mothers entered the labor force. The surrogate socializing agents--namely the media--have much less motivation to be concerned about what values and attitudes they are imparting to the next generation than do parents. Their primary motives, after all, are to sell programs and sell products, regardless of what it takes. The effects of these structural changes in the social control and socialization systems were then compounded by a major demographic change: the baby boom was reaching adolescence and by its sheer size was placing stress on the ability of the educational and social control mechanisms of the society to function effectively.

Several major historical events coincided in time with these structural and demographic changes, and their cumulative effect was appreciable. Specifically, the advent of the Vietnam War and other subsequent politically and socially alienating events, like Watergate, had a tremendous catalytic effect on the popularity of drugs. The use of certain illicit drugs became both a symbol of defiance of "the system" and the older generation, as well as a symbol of solidarity among those of like mind (National Commission on Marijuana and Drug Abuse, 1972; Johnston, 1973).

As the somewhat naive earlier views of the dangers of drugs were challenged by both scientific and experiential evidence of the adverse effects of many drugs, young people began to back off selectively. Methamphetamine use diminished as the word got out that "speed kills." LSD lost some popularity in the early seventies as reports of its effects on the brain and on chromosomes, whether well-founded or not, spread. Daily marijuana use fell by more than half, accompanied by a dramatic rise in the proportion of young people perceiving such use as carrying appreciable risks for the user (Bachman, et al., 1988; Johnston, Bachman, and O'Malley, 1982; Johnston, 1985a). PCP use fell very quickly in the late seventies as its reputation on the street as a dangerous drug grew.

But certainly other factors also played a role in the reversal of the overall epidemic. Among those which seem most plausible were the passing of the Vietnam era; the wearing off of the "fad" quality of drug use; the sobering influences of the recession of the early eighties and the shortage of entry level jobs for the baby boom generation, which led to more concern with job attainment and thus school performance; and the whole healthy lifestyle movement (Johnston, O'Malley, and Bachman, 1987b).

But while some of those, and perhaps other factors, may cause the epidemic to recede even further than it has, two major changes make it highly unlikely that this country will ever be able to attain the very low levels of illicit drug use seen in the 1950's. First, the vast production and supply network which now exists will make drugs accessible to American young people for the indefinite future. Second, there is now a widespread awareness among American youngsters of a whole range of chemical options for altering mood and consciousness. This was an awareness which surely did not exist in the fifties. In addition, the process of natural correction in use which occurs as the dangers of a drug become established and widely known, is overcome in the aggregate by the continual introduction of new allegedly "safe" drugs. Cocaine is a fairly recent example from the seventies, "ecstasy" (MDMA) a more recent one.

In recent years, there have also been changes in the purity of some of the more important drugs as well as in the methods by which they are ingested--changes which generally have meant that drug use is becoming more dangerous. "Black tar" heroin from Mexico is a very pure form, contrasting to normal street heroin which often is only 5% pure in the American market; thus more overdose deaths result. Cocaine is now available in an inexpensive "crack" form--a smoked form which is purer than the normal powdered form of cocaine hydrochloride, and which thus can result in a much more rapid addiction, as well as more frequent overdose. Marijuana is also reported by the Drug Enforcement Administration to be considerably stronger than ten years ago, although the importance of this for the user is yet to be determined, since users may well titrate their intake to get a desired level of effect. (In fact, national data from high school seniors suggest that there has been some decline in both degree and duration of the high usually obtained with marijuana. See Johnston, O'Malley, and Bachman, 1987a.)

In 1985 the decline in the use of most drugs appeared to have stalled among high school students and young adults (in fact, the active use of cocaine was rising), serving as a reminder that continued improvement cannot be taken for granted. Fortunately in 1986, the downturn resumed and in 1987 even cocaine showed the first signs of a turnaround. Usage rates in this country are still very high by long-term historical standards, as well as by comparisons with nearly all other countries in the world (with the exception of neighboring Canada). Thus, continuing to attempt to reduce the use and abuse of drugs remain a pressing item on the national agenda, and seems likely to remain so for the foreseeable future.

Supply Reduction Strategies vs. Demand Reduction Strategies

Virtually all approaches to the drug abuse problem may be categorized as attempts either to reduce the supply of drugs or to reduce the demand for drugs. Supply reduction strategies range from foreign policy efforts dealing with other governments (e.g., the recent crop eradication efforts in Bolivia, and crop substitution in Southeast Asia), to interdiction and border control, to techniques for the apprehension of suppliers and dealers as well as prosecution and punishment policies for them (e.g., seizure of assets laws). Demand reduction strategies, on the other hand, attempt to alter factors in the individual or his/her environment that predispose, stimulate, reinforce, or enable his/her drug using behavior. These strategies range from deterrence efforts based on law enforcement, to attempts to change individual knowledge, skills, and beliefs, to attempts to alter conditions in the social or cultural environment which support or contradict drug use.

Only limited attention will be given here to the specifics of supply reduction strategies, partly because it is this side which has received a very disproportionate amount of the attention in comparison with the complementary side of demand reduction.

Indeed, it seems that the most serious and overarching policy issue in the drug abuse field has to do with the balance in resources and emphasis addressed to supply reduction and control vs. demand reduction and control. What follows is an overview and critique of current supply and demand reduction approaches.

Supply Reduction

Policy issues surrounding the drug abuse problem are quite different than those related to the use of other consumable and abusable products, in that most of the illicitly used drugs are not legally manufactured, nor sold or distributed through legal channels to their ultimate consumers. Therefore, many of the points of policy intervention dealing with quality control and manufacture, labeling, advertising, point of purchase controls, taxing and pricing, etc., are beyond the normal span of governmental influence. This situation contrasts vividly, for example, with legal consumer products such as cigarettes or alcohol. On the other hand, with illegal drugs there exist some qualitatively different policy issues, having to do with attempts to eliminate the illicit production and the illicit supply systems.

It seems that there is an almost universal governmental reflex to try to solve the drug problem with supply-reduction, law-enforcement approach, not just in the United States, but in most countries. (Insofar as demand reduction is part of the strategy, it is again in the law enforcement mode, with the emphasis on catching and punishing users.) It also seems that in most Western democracies this reflexive approach has been relatively ineffective, for reasons which seem clear after some thoughtful economic analysis.

After all, drugs constitute a consumer market, albeit an illicit one, in which operate the same forces of supply and demand found in most markets. Basic economic theory posits that when demand for a product expands, prices will rise, and the supply will expand to meet it (assuming that there is not a controlling monopoly or oligopoly) either as a result of current producers increasing production and/or as a result of new producers entering the market. When the market is extremely profitable, there will be a rush of new producers entering. They will tend to flood the market with the product, and prices will tend to decline as suppliers compete with one another for market share and for optimizing their individual profits. That is exactly what has happened with cocaine in this country, for example.

It is common knowledge that the profit level in the illicit drug market is utterly enormous--in the tens of billions of dollars. Therefore, from basic economic theory it seems predictable that there will be a continuous flow of new producers, wholesalers, and retailers scrambling to attain those enormous profits, until the profits get so low that they are not worth the costs (including the legal risks) of entering the market. It seems highly unlikely that profits ever will get that low in a Western democracy, where the most draconian measures are shunned, as long as there remains an appreciable demand; thus there is likely to be an endless supply of suppliers. Indeed, many people who might otherwise have been law-abiding citizens have found their price and have decided to enter this highly profitable illegal trade.

With regard to international production, the fact that a fair proportion of the world's countries are not under serious international control means that production can always move beyond our international reach. Witness Afghanistan, Iran, Lebanon, and the Eastern bloc countries. Further, even some countries with a genuine commitment to international cooperation may not be able to eradicate production within their own borders, due to a lack of control over certain remote regions (e.g., Thailand, Burma, Colombia, Peru, and Bolivia). Thus, attempting to eliminate the supply through international efforts may show some short-term successes (e.g., as in Turkey and Mexico); but in the longer term, replacement supplier countries will continue to enter the market. Even in the highly unlikely event that we managed to attain a kind of global control on the production of natural drugs, such as opium and cocaine, the potential for chemical analogues is such that these natural drugs surely would be replaced by synthetics; and the control of synthetic drugs can be even more difficult, since the means of production are so much less visible.

In sum, despite dramatic efforts, and very large-scale investments of energy and resources by governments, it seems likely that we will not succeed in reducing significantly the production of drugs at the world level as long as the demand--and thus vast profits-- remain. Indeed, we have escalated our own expenditures on supply reduction dramatically in recent years, at the very same time that availability has increased in the United States (Drug Enforcement Administration, 1987; Johnston, et al., 1987). See Figure 7 for the relevant data for high school seniors.

It does not follow from this analysis that supply reduction is a strategy which should be abandoned. Undoubtedly we must continue to try to suppress the production and distribution of drugs. The major point is that by focusing almost exclusively on trying to win the unwinnable battle of supply reduction, as a society we largely have neglected the battlefield on which we could win the war, namely the battlefield dealing with the demand for drugs.

Demand Reduction

Coercive Techniques. Society has traditionally attempted to reduce the demand for drugs through policy strategies based on legal deterrence and other social control mechanisms. Two such policy initiatives have included changes in the legal status of certain drugs and recent initiatives to identify drug users through urine testing.

Deterrence through legal sanctions has been the most widely used approach for attempting to discourage the use of illicit drugs: such drug-using behaviors are rendered illegal by the state, and appreciable punishments are prescribed for infractions. The degree of enforcement effort, and the ability of authorities to successfully apprehend and punish those who break the law, obviously are critical moderating variables in determining the deterrent potential of the legal approach. So are the visibility of the behaviors in question and the willingness of the general public to report infractions of the law and to cooperate in prosecution.

In general, local law enforcement agencies have not placed a very high priority on the apprehension of drug users (as opposed to dealers). This may partly be because users are often seen more as victims than victimizers, but surely it is partly because of the extremely high numbers of users in recent years, in conjunction with the related fact that many are otherwise law-abiding citizens. Add to these the additional factors that (a) drug use is easily concealed and (b) that within certain age groups the norms have been sufficiently tolerant of drug use that there has been little cooperation with law enforcement, and it should come as no surprise that legal sanctions have not been spectacularly successful.

In the 1970's there was a far more active controversy than exists today about the proper legal status of drug use. Specifically, there was a strong demand for decriminalization of marijuana, which was the drug that received the most attention by public officials and the media during that decade. The arguments for decriminalization were numerous; but central among them was the notion that apprehending, arresting, and giving criminal records to large numbers of American young people, who otherwise were law-abiding citizens, was not in the public interest. (In the peak years arrests for marijuana possession were averaging around 400,000 per year.) The major counter-argument was that the arrest and conviction of drug use offenders would help to deter the use of the drug among young people, in particular.

As it happened, a natural experiment occurred in the country, as a result of the fact that these laws are determined primarily at the state level. Some states decriminalized marijuana use, while the majority of states did not. Since the Monitoring the Future study was already ongoing, it provided the basis for a prospective study in which drug use before, during, and after decriminalization in the states which decriminalized could be compared with usage trends in the states which did not decriminalize. The results indicated that decriminalization during that period had virtually no effect on the levels of drug use among young people, nor on their attitudes and beliefs about drugs (Johnston, O'Malley, and Bachman, 1981). This failure of the change in the law to affect even attitudes and beliefs strongly suggested that there would be no longer-term effects on use, either. Other retrospective studies of decriminalization in particular states have come to much the same conclusion. There are questions, or course, about whether the rates of enforcement and prosecution, even in those states where use remained illegal, were such as to provide very much contrast to the decriminalized states; but it can be said with near certainty that, within the range of state policies that then existed, there was no evidence of a differential result coming from active decriminalization of marijuana.

Only limited generalizations can be made from such a conclusion, however. Marijuana was, after all, a very widely used drug among young people, and one which was widely accepted and consistent with the existing social norms of their age group. Thus, the symbolic impact of decriminalization would be expected to be very limited in that historical period.

It also should be noted that decriminalization and legalization are quite distinct things. The production, distribution, and sale of marijuana remained illegal even in decriminalized states, no advertising was possible, and so on. Recent calls by some social commentators for the legalization of drugs would involve a qualitatively quite different social action. Complete legalization likely would have a considerably greater impact on use than decriminalization, partly because the use of most other drugs remains highly illicit in the society and contrary to social norms (even among youth) and partly because legalization constitutes a far greater liberalization of the law. Under legalization, all of the policy issues having to do with production, labeling, advertising, purchase restrictions, taxation, etc. would suddenly become germane.

Demand Reduction Based on Changing Attitudes, Beliefs, and Norms. So far, the demand reduction techniques discussed have been those which rely entirely on the use of negative incentives or reinforcements--including techniques for apprehension and punishment. These approaches are not aimed at changing the person, but rather at changing the contingencies presented by the environment as a result of drug use, and the probability that the consequences will be incurred. Their success relies largely on the extent to which drug using behaviors in the population can be monitored, since the desire for compliance is not internalized by the individual. There is, however, an important additional class of interventions which do aim to change the person, and they are often spoken about under the rubric of prevention. The so-called prevention approaches have been at times classified into three levels: primary prevention (which means reaching people before they ever start using drugs or a drug); secondary prevention (which means intervening early in the drug involvement process, before the users become dependent or chronic users of the drug); and tertiary prevention (which means dealing with people who already have an established drug abuse problem, i.e., treatment). Primary prevention, early intervention, and treatment are the terms now more in vogue for these three levels.

To deal with the last first, of the three types of prevention approaches the treatment of drug abusers has been the dominant focus of demand reduction to date.

However, treatment may be seen as the result of a society's failure to succeed at, or even to attempt to implement, the first two stages of prevention. It is dealing with the casualties; and it is a very expensive approach with rather limited success. While treatment of most drug abusers seems well worth society's investment in terms of pay-back in productivity, reduced crime, and now in terms of AIDS prevention, it is nevertheless very expensive per case and even more expensive per successful case. Recidivism rates tend to run high, approaching and often exceeding 50%.

So-called secondary prevention, or early intervention, would seem to hold promise in that those most at risk for drug abuse have begun to identify themselves by their early involvement, and thus scarce resources can be focused on those most "at risk" of developing a serious problem. The drawbacks in this approach, of course, are that the early users are not that easily identified and engaged in the intervention process, and further many are already well on their way to serious involvement with drugs and/or with dysfunctional social groups, making successful intervention more difficult. Nevertheless, this appears to be an area in which some creative and positive approaches could be developed for early identification and intervention.

Primary prevention might be thought of in two subclasses--selective and global. Selective primary prevention occurs when individuals or groups, judged to be at high risk for reasons other than their actually using drugs, are identified and resources are focused on them. The second category, which might be called global primary prevention, exists when all people in a population group are provided an intervention, whether or not they show indications of being prone toward drug abuse.

Given the extremely widespread nature of drug use among contemporary American youth, it would seem that global drug abuse prevention efforts are highly justified at the current time, and perhaps for the foreseeable future. Further, they need to start at a very early age given the age at which illicit drug use begins (see Figures 1 and

2). More focused or selective drug abuse prevention efforts may additionally make sense, even in the presence of global ones, however. In general it would seem that we should be exploring demand reduction using all of these types of approaches. As is discussed below, new mechanisms to increase the generation and refinement of additional approaches to primary and secondary prevention would be extremely valuable. Indeed, mechanisms which would bring about a realignment of the federal strategy to place a higher level of resource allocation on the development of a knowledge base for primary and secondary prevention seem to this author to be essential.

Building a Knowledge Base for Prevention

Intervening successfully to prevent or ameliorate social problems is a high risk venture. If one takes Donald Campbell's (1969) notion of "an experimenting society," one comes to see most knowledge on social engineering, or social intervention, as developing through a process of trial and error with evaluation. Of all the seemingly good ideas for preventing drug abuse (or for intervening in most other non-adaptive behaviors) probably 70-90 percent will prove either ineffective, or actually to result in adverse consequences, for reasons that are simply beyond the ability of the theoretician or social planner to forecast. (This seems now to be the verdict on most of the "good ideas" for drug abuse prevention that were popular into the seventies, like the "information approach" and the "alternatives approach" (e.g., see Schaps et al., 1981.) If one accepts this assumption, it means that it is critical to implement as many of the most promising ideas as possible in experimental designs, to evaluate them as rapidly as possible, and to identify the minority of programs that do work. Those programs can then be disseminated widely. Most important, the majority of programmatic intervention funds, which otherwise would have been wasted on ineffective programs can be used on the effective ones.

Three key stages to such an experimental approach to building a knowledge base can be distinguished: idea generation, program development, and systematic evaluation. The chapters being contributed to the current volume, for example, all fit into the idea generation stage. The position is taken here that all three stages are critical to the development of a knowledge base, and that the process by which we have been developing that knowledge base should be a high priority subject for focused attention. In particular, the issues of resources and strategy need to receive consideration.

The overall strategy I would recommend is that we greatly increase the rate at which new prevention approaches are being developed, built, and refined into programs which can be implemented and evaluated in (often large-scale) systematic research designs. This will require a different scale of resources being allocated to knowledge development in the field, additional institutional mechanisms to expand and improve the process, and sustained attention and support.

Idea Generation

Regarding the first stage--that of idea development--an overall examination of the literature suggests to this author that (a) the range of ideas which have been put forward and tried for preventing drug use has been very limited in contrast to the range of interventions which might be developed and judged promising, and (b) most of those which have received serious, systematic evaluation so far have not shown evidence of a great deal of effect. I do not conclude from the latter assertion, by the way, that nothing effective can be done--only that we have not made an adequate effort to find the "right" answers.

How might we increase the production of new and promising approaches? The commissioning of papers like the present ones is one approach, and I applaud it; but we cannot rely on one-shot strategies. There needs to be a well-thought-out, ongoing process. I would argue that one structural mechanism to help assure such an ongoing process would be the creation of several ongoing Prevention Development Centers, which would have idea development as their primary mission. They could have resident and visiting scholars, like most think tanks, and could commission papers; but I believe they should also make use of the practical knowledge and insights of people who are (or have been) in many of the social roles that touch on the drug abuse problem. The notion would be to bring together people from roles such as the following: youngsters who have (had) drug abuse problems, youngsters who have managed to avoid drug use, parents of both types of youngsters, drug abuse counselors, teachers, school counselors, youth workers, and so on. The purpose is to draw upon their knowledge and insights, using groups of various permutations of such roles to develop new perspectives--much as advertising agencies use "focus groups" to develop an understanding of how people feel about a product, why they might buy it, what forces influence their decisions, and how they would react to various advertising interventions. People from such roles could be brought together for short sessions of a day or less, or for longer ones of a weekend, week, or more. Whatever heuristic devices (e.g., the Delphi technique) are judged by the center staff to be promising should be tried. The main point is that an organization, and a set of professionals (as well as non-professionals) is given the sole task of generating new approaches to prevention.

I could imagine that some of the most valuable ideas to be generated might relate to ways in which adolescents themselves structure their activities, social groupings, and reward structures so that (a) there is less pressure to use drugs and alcohol, (b) there are attractive social alternatives to "partying," (c) there is less reward associated with it, and (d) there are some social penalties. Developing effective ways for coopting young people into helping to solve their own problems would be a primary goal, I would hope.

It would also seem likely that some models might emerge for intervening in parental and family systems. How might the influence of older siblings be used constructively, and how and when might parents organize among themselves. Despite all the work of the existing parent group movement, I think parents are organizing too little and too late--a point to which I return below.

Effective ways for recording and communicating the most promising of these ideas would need to be developed; and the reports resulting from the centers should be placed in the public domain, so that anyone moved to develop and implement one of the ideas is immediately free to do so.

Program Development

Klitzner (1987) and others have argued convincingly that often not enough time is devoted to the intermediate stage of program development, before summative evaluation of an approach is undertaken. I would agree with this observation. Developing, pretesting, and further refining a program built on a general idea for a prevention intervention is an important and sometimes difficult stage in the process--and adequate time and resources need to be made available for all of this. The recently created Office of Substance Abuse Prevention (OSAP) within ADAMHA now has significant funding available for demonstration projects in prevention, though more might be usefully allocated for this purpose from within the Department of Education, as well. One would hope that a number of the new ideas to emerge from the Prevention Development Centers would be put forward for the funding of program development. Since this is not an area with which I have a great deal of first hand experience, I am not sure whether any special institutional mechanisms--such as Program Development Centers--might be facilitative or not. It is, of course, possible that this stage of work could be encompassed by the Prevention Development Centers, just discussed.

Program Evaluation

To properly evaluate social interventions often required appreciable time, resources, and technical expertise. As a matter of general policy, I think that we should be sure that all these are made available, given the seriousness of the drug abuse problem in the country. To date, the Federal resources available have been inadequate to the task. OSAP is prohibited by its enabling legislation from sponsoring evaluation research. NIDA has had relatively insignificant funds for such purposes. The net result is that the area is relatively moribund, and some significant scholars have become disaffected and left the area. There is a clear need for a vigorous Federal effort in this area--one which logically might be shared between NIDA and DoE.

The Need for Sustained Attention and Support

It is a pervasive flaw in American thinking that we act for the short term and let the long term be damned. Significantly increasing the knowledge base is a long-term process, and we need to think of it that way. Making matters even more difficult in the development of knowledge for effective social interventions, is that it requires an experimental perspective in which it is realistic to suppose that perhaps a majority of what look like "good" ideas ultimately will fail to bear the desired fruit. That means that policy makers, administrators, and scientists need to be tolerant of the unfruitful efforts and also to remain optimistic that others will prove fruitful. The field, and the effort, should not be judged barren just because many, or even most, of the approaches are. Failure needs to be seen as a necessary part of the experimental process by which we identify the most successful approaches.

Another caution concerns the danger of dismissing a general approach too quickly just because a particular incarnation of that approach proves unworkable or ineffective.

One example of such a process was the premature conclusion reached by prevention professionals in the 1970's--namely, that the risks of drugs fail to deter children from using them. The early prevention programs emphasizing the dangers of drugs were proven not to be successful, the approach was labeled "scare tactics," and in general this approach to influencing youngsters was dismissed by the field. I think this was a case of throwing out the baby with the bath water--and certainly there was a lot of bath water in the early seventies in the messages being given to youngsters about drugs. The problem was that the messages were not credible: in general younger people knew more about drugs than adults, and they began to dismiss all communications from adults about drugs as propaganda. Since then I think "the system" has gained back much of its credibility by sticking closer to the facts. Some of the evidence for this is that many more young people have come to see marijuana use as dangerous than used to, and that their actual use of marijuana has dropped appreciably. In fact, one of the most important findings from the national high school surveys has been that young people's tendency to use a drug, or to avoid using it, is on average substantially influenced by what they perceive as the dangers associated with using it. Figure 8 shows the dramatic change in the perceived risk for regular marijuana use over the period 1978 to 1987, during which daily use fell by more than two-thirds--from 10.8% to 3.3%.

Further evidence of the importance of perceived risk came in 1987, when we reported that the perceived risk for experimental cocaine use was up sharply for the first time among adolescents and young adults (see Figure 9). This change was accompanied by the first appreciable drop in active cocaine use since the study began in 1975 (Johnston, 1988).

So, the approach of emphasizing risks was valid in my opinion. It was the particular implementation of that approach during the early 70's that was not.

Some Potential Programs and Approaches to Prevention

By way of background to this section I would say that I do not think there are any "silver bullets" available in our potential prevention armamentarium. The problems being presented are as varied and complex as are their causes. Further, techniques which may be effective with some groups in the population (defined in terms of age, sex, social class, urbanicity, ethnicity, and so on) may not be effective in others. Therefore, I believe that the best national strategy is to develop a host of different programs--preferably of demonstrated feasibility and effectiveness--which are to some degree tailored to various of the target populations.

Two global types of prevention programming, already in place and impacting large numbers of people, are school-based prevention curricula and prevention-oriented media campaigns. Therefore, I will begin this section by discussing the information available from the Monitoring the Future project concerning breadth of coverage and the judged effectiveness of those two massive programs.

School-Based Prevention Curricula

Table 1 shows the proportion of American high school seniors in recent graduating classes who report having received drug education courses or lectures in school. It shows that in recent years a significant portion of students report having had no such experiences--from 25% to 30%. Also on Table 1 are the proportions reporting each type of curricular element while in high school. Three quarters of those having had such experiences report having films, lectures, or courses in one of their regular classes. Only slightly over a fifth of them report taking a special class about drugs. Films or lectures outside of courses are now reported by over a third of those having any courses or lectures, and this is the only category of such experiences which appears to be rising over time in terms of the proportion of the school population reached.

Table 2 shows that, of those who received any of these curricular experiences, less than one in five (18%) thought they were of "no value" but, then, less than one in five found them of "great value." Over half (55%) thought these educational experiences had decreased their interest in trying drugs to some degree, while only two percent said it made them more interested; 43% felt it had no impact. So, in general, today's teens clearly are more favorable than unfavorable about the drug education they are receiving, if we leave aside the ones who don't receive any. Surely there can be no doubt, however, that there is still plenty of room for improvement.

None of these results, by the way, show much of any trending since the mid-1970's, including their ratings of the value or impact of what they have received. To the extent that there is any trending, it is in the direction of their giving slightly better ratings to their curricular experiences today than in the mid-1970's. If evidence of this sort is needed, it would seem to suggest that on average drug prevention curricula are of some value, that there is still an important segment of the population not reached by such curricula, that there is plenty of room for improvement in the ratings, and that there has occurred relatively little improvement in the ratings during the past ten or twelve years.

For the reasons cited earlier, it would seem that school curricula should emphasize the health risks of the various drugs (and I would include here the risks to psychological and social health, as well as to physical health). It is critical, however, that they do so in a way in which both the message and the message-giver retain credibility.

But clearly emphasis on the risks should not be the only component of such a program. In addition to trying to increase students' motivation to avoid drug use--as an emphasis on the risks is likely to do--it would seem critical to try to impart to them the social skills which would allow them to act consistently with that motivation. In essence they must be taught how to manipulate the salient contingencies--many of which are social--so that more reward than punishment derives from the avoidance of drug use.

There now exist some peer-based social skills programs which show promise in this regard (Pentz, 1988). One way in which I would like to see the notion of manipulating the contingencies elaborated is to see how students collectively, in addition to individually, might act to change the contingencies. No doubt it can be done: the question is can enough creative energy be mustered to figure out how?

Another observation I would make about school curricula is that drug-prevention components should be introduced very early (See Figures 1 and 2 for grade of onset estimates) if they are to reach youngsters before many, or worse yet some "critical mass" of them, already have begun to use drugs. Some components should probably be built into the curricula at every grade thereafter, as well, to be sure that reinforcement or "booster" effects keep occurring and cumulating.

My final comment on school curricula programs is that they should encompass the dangerous licit, as well as illicit drugs. This means at a minimum cigarettes, alcohol, and chewing tobacco. This is important because (a) these substances themselves pose very significant health risks for the population; (b) in order to be consistent in any prevention arguments based on health concerns, it is necessary to cover these substances; and (c) the use of these substances is highly correlated with subsequent use of the illicit drugs, likely reflecting in part a causal connection.

Media-Based Prevention Efforts

The media by default have taken over a very significant part of this society's education and socialization of its children. With regard to both licit and illicit drug use I would say that, in general, this has been a highly unfavorable development. However, for the last year or two the media collectively have undertaken a considerable public service advertising effort to deglamorize illicit drug use. Given the clear power of the media with young people, I view this as a most constructive and promising undertaking. In 1987 for the first time, the Monitoring the Future study contained questions about such anti-drug commercials. As the results in Tables 3 and 4 show, young people seem to be getting a high rate of exposure to these prevention "spots" and to have a very encouraging assessment of the impact of these commercials on their own propensity to use drugs. Importantly, few think that the commercials have exaggerated the risks.

Since those are admittedly self reports of impacts, rather than statistically demonstrated effects, one has to be cautious about interpretation. Nevertheless, given the low propensity of most adolescents to admit that anything affects them, I take these results to be highly encouraging with regard to the potential of media campaigns.

One obvious suggestion is to keep alive the current national program, most of which is occurring under the auspices of The Media-Advertising Partnership for a Drug Free America. Another might be to have local communities develop their own complementary campaigns, with the help of local advertising professionals, perhaps using the referent power of local figures. This is an approach I am currently encouraging be adopted on a trial basis by a community leadership group in Detroit called The Prevention Forum, which is sponsored by the Community Foundation for Southeastern Michigan. If a successful model could be developed, it might be imitated in many major metropolitan areas; and, as the next section discusses, changing young peoples' perceptions of community norms may be a very important part of the process.

Perceptions of Drug Use and Related Attitudes Among Public Role Models

The perceptions of young people concerning how much illicit drug use is used, as well as how it is viewed, by important role models in the mass culture have long been assumed to be factors having an important influence on their own behavior and attitudes. Interestingly there has been rather little research on the subject. In 1987, for the first time, questions were added to the Monitoring the Future studies aimed at measuring these perceptions with respect to three important referent groups--professional athletes, rock musicians, and actors and actresses.

The results show that a substantial majority of young people believe that illicit drug use is widely practiced in all three professions, with rock musicians seen as having the highest proportion using drugs, actors and actresses the second highest proportion, and professional athletes ranking third (see Table 5). The median answer for rock musicians is the estimate that about 70% of them are using illicit drugs occasionally or regularly; for actors and actresses the median is at about 55%; and for professional athletes at about 50%. In other words, about half the seniors guess the proportion of each group using drugs to be higher, and half lower than these numbers. While I am unaware of any systematic surveys of these three populations, my own guess is that these are substantial overestimates of the prevailing behaviors in these populations.

Likewise, young peoples' perceptions of prevailing attitudes in these same three populations appear likely to be off the mark--with their perceiving much more acceptance of illicit drug use than seems likely to exist. Table 6 shows that the great majority of young people do not think there is widespread disapproval of illicit drug use in any of these three influential role-model groups. The students were also asked what proportion of people their own age strongly disapproved of "using illicit drugs (like marijuana, cocaine, etc.) occasionally or regularly?" The majority thought that less than 50% of their age peers felt that way. Table 7 gives the actual distributions of the attitudes of their age peers, and with a little interpolation, it seems fair to conclude that most students underestimate the extent of peer disapproval.

The point for prevention strategy is that we may have a case here of "collective ignorance," which could be attacked directly through both media spots and in-school curricula. I would think many in the three professional role-model groups would be appalled to think that youngsters see their profession in the way they do and would be willing to speak in public about their own attitudes and practices regarding drugs. I think their professional associations might play a vital role in bringing about such a program, and the advertising industry might assist by volunteering their professional communications skills, as they have so generously in the past. The data provided in Tables 5, 6, and 7 might provide the needed stimulus to motivate such professional action. (They might also be used to challenge students' beliefs about prevailing peer norms.)

The other approach which might be used toward the same end is to conduct representative sample surveys of people in the three key role-model groups. Assuming that their attitudes come out quite different than young people think, the results of the surveys could be used to develop persuasive messages challenging existing misperceptions.

Advertising of Alcohol and Cigarettes

Considering the very young ages at which most eventual smokers begin smoking, and at which young people develop patterns of regular smoking and occasional heavy drinking (e.g., see Johnston el. al., 1987), it is difficult to conclude that the massive advertising of both cigarettes and alcohol is not relevant to preventing substance abuse among our young people. In the course of childhood each youngster is exposed to thousands upon thousands of commercials which associate these products with many attributes of great attractiveness to young people. The annual advertising and promotion budget for cigarettes alone now exceeds two billion dollars. This author has made the point elsewhere (Johnston, 1986) that the advertising and promotion of cigarettes should be totally banned given the known dangerous consequences of the product, even when used as intended--not to mention the likely derivative consequences of smoking contributing to illicit drug use. It has also been argued that alcohol advertising should be severely curtailed for many of the same reasons (e.g., Johnston, 1985b).

Really, the advertising of these products does exactly the opposite of what existing anti-drug advertising tries to do--glamorize drug use vs. deglamorize it--and the opposite of what the activities recommended in the preceding section would try to do. That is, product advertising gives the impression that more people are consuming these drugs (and in the case of alcohol, in particular settings), than is really the case. The advertising budgets for these two drugs make all of the nation's prevention activities in the areas of illicit drugs, cigarettes, and alcohol, combined seem utterly insignificant by comparison. As long as we allow self-serving institutions in the society to urge drug use--broadly defined--upon our children, we can expect to be much less successful in any organized prevention attempts in my opinion.

Mobilizing and Networking Parents

The drug epidemic of the last twenty years has added a new dimension of difficulty for those who must raise children. At the same time that these new opportunities and pressures to use drugs were placed upon their children, families on average became less well equipped to exert constructive social control and influence over their children. As has been mentioned earlier, the greatly-increased divorce rate and the simultaneous rise in the proportion of mothers working, has of necessity reduced parental monitoring and awareness of their children's behavior. Having a more mobile population has surely also contributed, in that extended family are less likely now to be around to help exert adult influence; and neighbors are now less likely to know neighbors, leading to much the same result. Finally, more youngsters are physically and financially independent of their parents with fair proportions having cars and paid work.

If the erosion of family and neighborhood control has, as I have hypothesized, contributed significantly to the drug problem (as well as to other problems), one remedy is to see if there are ways to empower parents more in their parental roles and to help train them specifically to deal with this new class of problems.

Of course, because the drug epidemic is now two decades old, on average parents today probably are more knowledgeable about drugs and the drug culture than parents were in the sixties and seventies, if for no other reason than that many of them passed through their own adolescence and young adulthood during the epidemic. But knowing what to do as a parent is a different thing from having been there as an adolescent. Further, the nature of the drugs and the drug culture itself have changed considerably over these years. (See opening discussion of the drug epidemic.) Thus parents are in need of guidance, social support, and collaboration with other parents in trying to deal with the threat of alcohol and illicit drug use among their children.

There has, of course, grown up a grass roots movement of parent groups in response to this need. However, the evidence is that it has reached a very small portion of the student population. The data presented in Table 9 show that only about 2.5% of seniors say their parents are actively involved in such a group, with roughly another 5% saying their parents have previously been involved in such groups. This means that only about one in fourteen youngsters have had one or more of their parents so involved, and in many of those cases it was probably after the horse was already out of the barn that the parents became involved.

Interestingly, most students think that parental involvement in such an activity is a good idea, while very few (only about 13%) think it is a bad idea (see Table 8). The data in Table 10, which are based only on those few students whose parents have been in such groups, paints a less promising picture in that over half felt the experience had no impact on their tendency to use drugs or (in a very small proportion of cases) made them more likely to use drugs. And only about a third thought it improved their relationships with their parents. However, it must be remembered that (a) many of these youngsters were probably already involved with drugs when their parents got organized; (b) the nature of what constituted a "parent group" undoubtedly varied in the extreme; and (c) many youngsters may be inclined to judge such parental activities more negatively now, since social control is involved, than they will later.

I would argue that new models for establishing and developing cooperative parent groups should be developed, refined, and evaluated. Serious consideration could be given to the schools playing a central role in the creation of such groups when the child is entering the first year of junior high or middle school, so that the horse is not already out of the barn, and so that the expectation that parents will play a more active and cooperative role in setting rules throughout secondary school will be established early, rather than be perceived as a removal of rights if introduced in the later years. I specifically suggest the beginning of junior high or middle school because that begins the period of heaviest initiation into drug use, and also because friendship groupings are often redefined after leaving primary school.

Obviously school leaders cannot "push" parents into doing this. Thus some creative mechanisms need to be designed to get the parents to help organize them and provide the momentum themselves. The Federal role could be to help to develop and evaluate models for accomplishing these ends, and perhaps to develop a high quality set of videotapes which could assist such groups. While I have a number of more specific suggestions for developing this approach, I will not take the time to go into them here.

A final caution. It appears to this observer that many parents shied away from involvement in the parent movement because it came to be perceived as ideologically to one side of center. The notion of parents being more actively involved in their children's lives, and in building consistent community norms, is neither liberal nor conservative at its nexus. Therefore, any implementation aimed at a broad segment of the population should probably be consciously designed to be acceptable to a broad spectrum of the population.

Changing Norms Among Teenagers

A number of the suggestions already discussed have dealt with the issue of ultimately changing norms among teenagers. Anti-drug commercials are aimed toward this end; and one of the reasons for suggesting that cigarette advertising be banned and alcohol advertising restricted, is to help change such norms. Most school-based prevention curricula also have this as one of their goals. However, enlisting the active involvement of young people themselves in helping to "turn things around" is a particularly important goal.

One approach that has been tried is to have anti-drug clubs for adolescents. Although the number of graduating seniors who report having been in such groups has been growing gradually (see Table 11), in 1987 only about one in eight reported any past involvement themselves. (Unfortunately, we did not allocate the question space needed to get adolescents' evaluations of the idea, or of their own experiences if they were personally involved. Such research would be valuable.)

However, I should state my own concerns about potential pitfalls of the approach of anti-drug clubs. It seems to me that there is a distinct danger that the set of youngsters who get involved (a) will be among the least likely to use drugs in the first place and (b) may serve as negative reference points for the youngsters most likely to get involved--perhaps hardening the latter's defense of their own position. Admittedly, all of this is conjecture, but I do think that these possibilities should be taken seriously and researched carefully.

However, creating formal anti-drug groups is but one method for trying to enlist young people in the search for solutions. Many other approaches can and should be tried within the general experimental framework discussed earlier. Certainly the different peer groupings which emerge in the high school (like "jocks," "burnouts," etc.) need to be taken into account in the development of different approaches. What works with one type of group may not work with another, and when peer leaders or facilitators or coordinators are chosen for various approaches, their position in the subgroup structure may be very important to their potential for success.

The last point I would like to make in this discussion of peer norms concerns young peoples' expectations and alternatives for having a good time socially outside of school. At present "partying" organized around substance use is a major form of recreation for American teenagers, and "to have a good time with my friends" is one of the major reasons given for most types of alcohol and illicit drug use (Johnston and O'Malley, 1986). There is a real need for alternative activities which meet the same basic needs--and which are acceptable and attractive to youngsters--which do not involve drinking and drug use. The Prevention Development Centers referred to earlier might pursue this problem-solving task with groups of young people. Surely some promising models could be developed and/or some procedures by which young people themselves attack the problem in their own schools and peer groups.

Concluding Remarks

The prevention ideas put forward here relate to a number of institutions and segments in the society--parents, schools, the media, advertisers, those in professions that serve as role models, community leaders, and young people themselves. This broad array is included because all of them, and still others not on the list, play a role--whether they like it or not--in either exacerbating or helping to solve the nation's drug abuse problems. To the extent many of those sectors can mobilize to help reduce drug use, I think it likely they will have a mutually reinforcing effect, since they will tend to convey the impression of a widespread intolerance for, and disapproval of, drug use. The problems, of course, are not going to go away completely, but I think it is well within practical expectations to see them very substantially reduced. I will close by restating my earlier caution that even if considerable success is attained, it is likely to require a long-term sustained prevention effort to successfully keep the problems from re-emerging.

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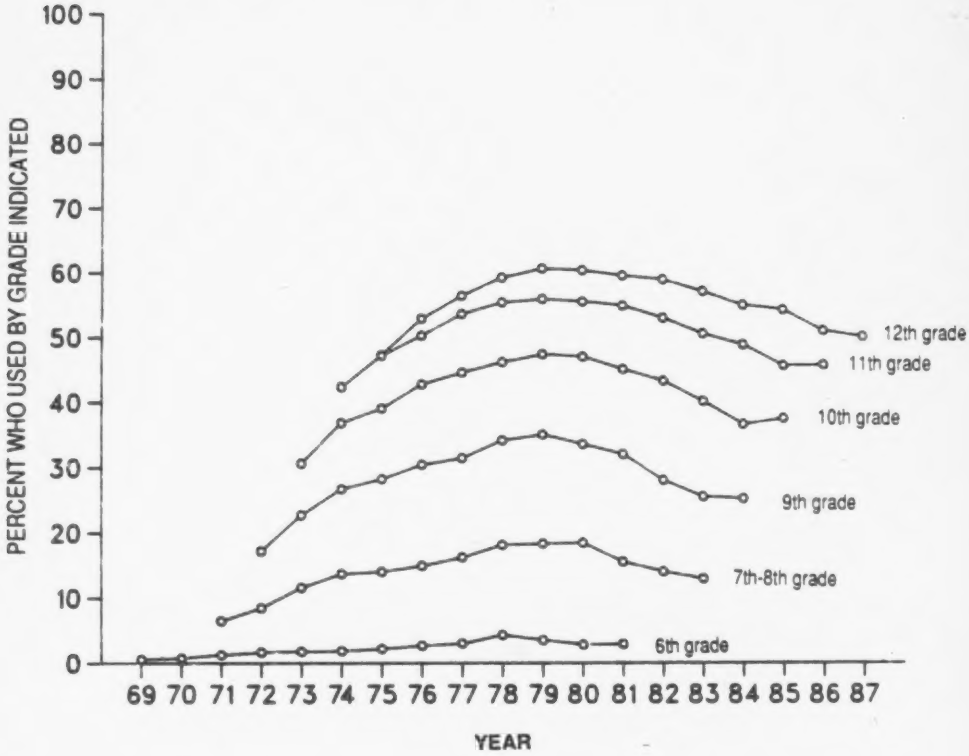
FIGURE 1

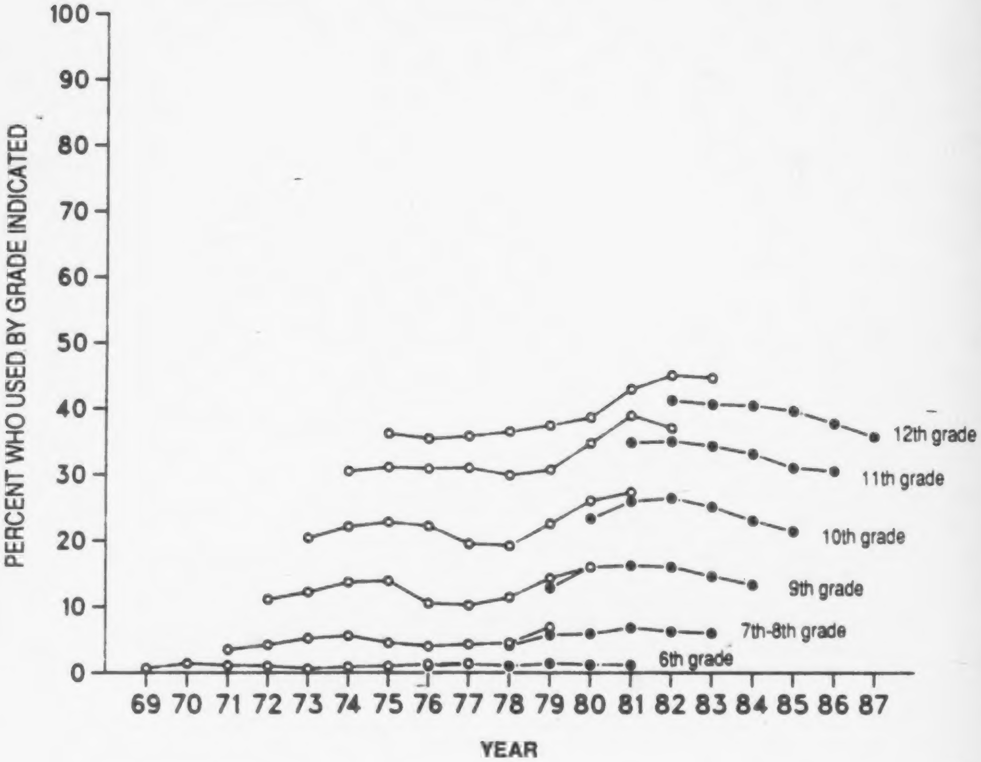
Marijuana: Trends in Lifetime Prevalence for Earlier Grade Levels
Based on Retrospective Reports from Seniors



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 2

Any Illicit Drug Other Than Marijuana: Trends in Lifetime Prevalence for Earlier Grade Levels
Based on Retrospective Reports from Seniors

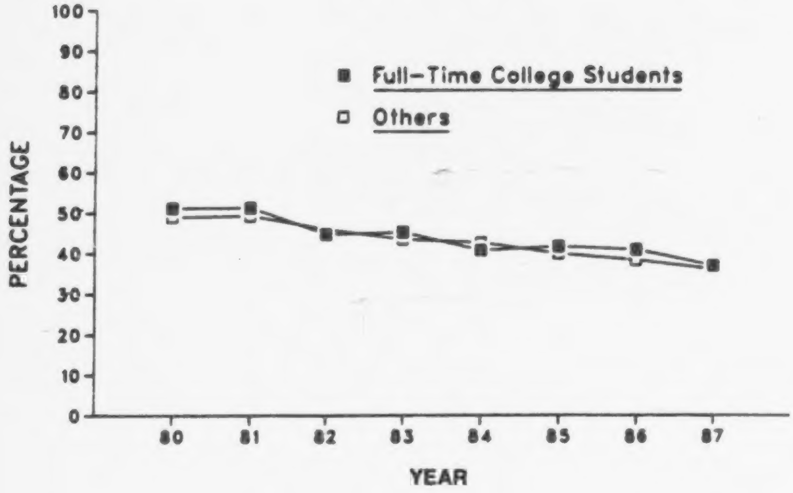


NOTE: The filled-in symbols represent percentages which result if non-prescription stimulants are excluded from the definition of "other illicit drugs."

SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 3

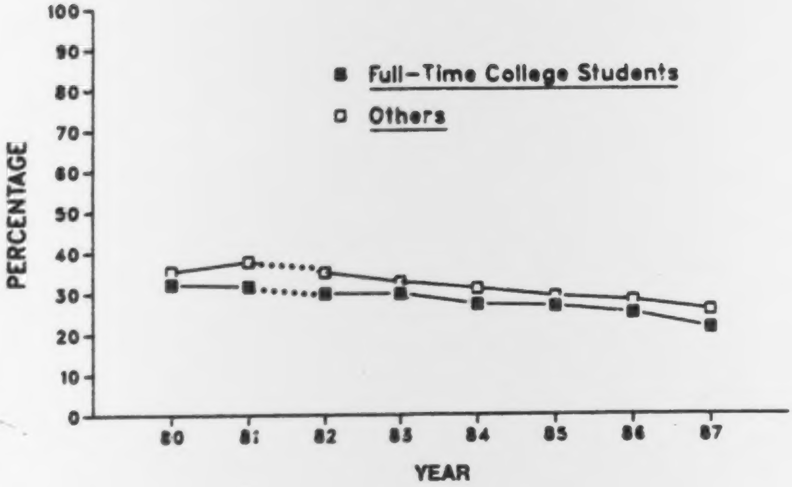
Marijuana: Trends in Annual Prevalence Among College Students Vs. Others
1-4 Years Beyond High School



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 4

Any Illicit Drug Other than Marijuana:
Trends in Annual Prevalence Among College Students Vs. Others
1-4 Years Beyond High School

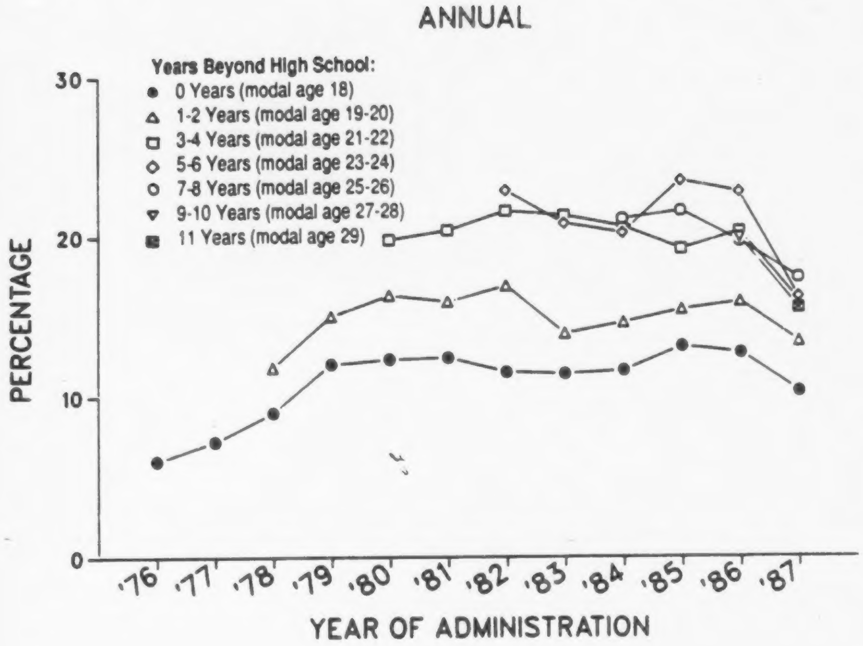


NOTE: The dotted lines between 1981 and 1982 denote a change in the amphetamines question.

SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 5

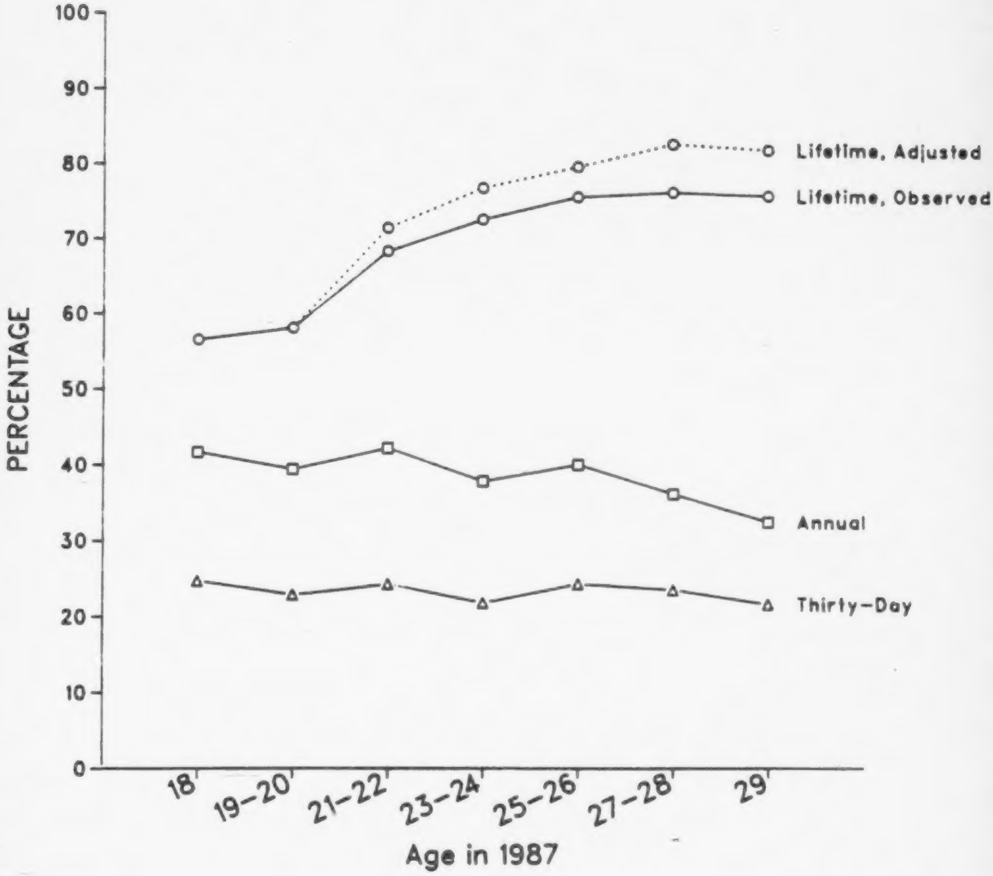
Cocaine: Trends in Annual Prevalence Among Young Adults
by Age Group



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 6

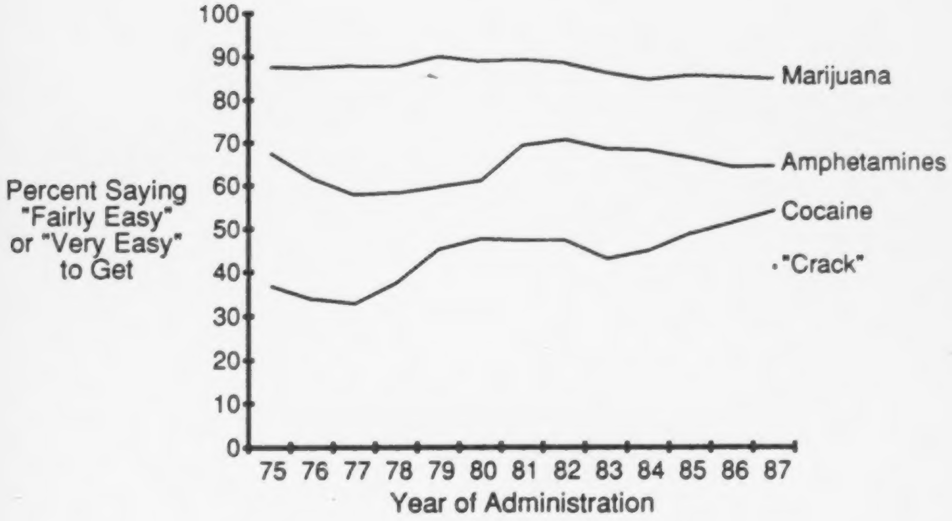
Any Illicit Drug: Lifetime, Annual, and Thirty-Day
Prevalence Among Young Adults, 1987
by Age Group



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 7

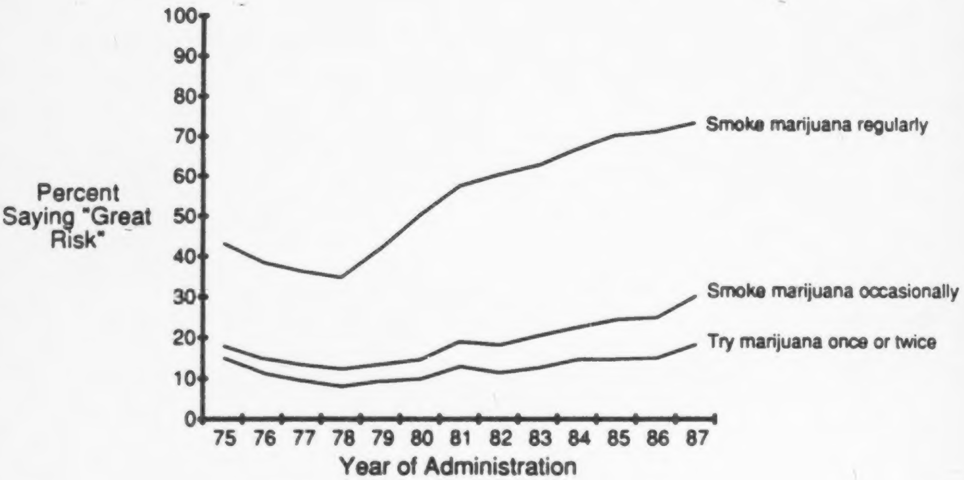
Trends in Perceived Availability of Marijuana, Amphetamines, and Cocaine
Reported by High School Seniors



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 8

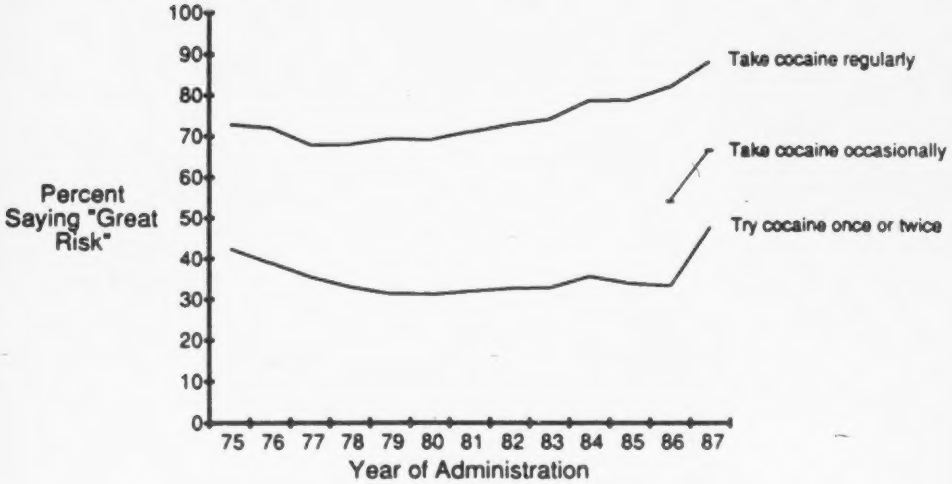
Trends in Perceived Harmfulness of Marijuana
Among High School Seniors



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

FIGURE 9

Trends in Perceived Harmfulness of Cocaine
Among High School Seniors



SOURCE: Monitoring the Future Study (Johnston et al., 1987)

Table 1

Exposure to Drug Use Prevention Elements in School Curricula

(entries are in percentages)

	High school seniors in the class of:											
	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
2E15. Have you had any drug education courses or lectures in school?												
1. No	15.7	18.0	20.7	21.0	26.1	23.5	26.2	25.6	27.3	23.9	23.8	21.4
2. No, and I wish I had	5.1	3.8	4.5	4.7	5.6	4.2	6.0	4.3	3.4	4.3	3.9	4.0
3. Yes	79.2	78.3	74.8	74.4	68.3	72.4	67.8	70.1	69.2	71.7	72.3	74.6
N=	*2494*	*2556*	*3000*	*2700*	*2710*	*2990*	*2975*	*2719*	*2688*	*2703*	*2568*	*2686*
Asked only of those having courses or lectures												
2E17. How many of the folowing drug education experiences have you had in high school? (Mark all that apply.)												
A. A special course about drugs	22.7	24.8	24.7	22.8	20.5	22.3	20.2	21.4	23.7	20.6	24.1	22.1
B. Films, lectures, or discussions in one of my regular courses	75.7	74.6	74.7	77.7	76.3	76.8	75.5	77.1	78.0	76.2	77.4	75.1
C. Films or lectures, outside of my regular courses	28.8	28.2	25.5	22.3	21.0	23.9	25.2	23.9	26.8	30.0	30.4	36.6
D. Special discussions ("rap" groups) about drugs	24.7	24.1	25.1	22.1	22.4	20.8	20.7	21.2	21.3	19.1	22.5	25.9
N=	*1979*	*1984*	*2227*	*1980*	*1820*	*2141*	*1987*	*1897*	*1841*	*1929*	*1840*	*1977*

Source: Monitoring the Future

Table 2

Ratings of School Curricula in Drug Use Prevention

(entries are in percentages)

Asked only of those having drug education courses or lectures	High school seniors in the class of: 1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987
2E16. Would you say that the information about drugs that you received in school classes or programs has . . .												
1. Made you less interested in trying drugs	50.5	54.0	51.5	52.4	55.3	58.8	56.9	54.7	54.1	55.6	57.2	54.9
2. Not changed your interest in trying drugs	45.6	43.0	45.2	44.0	41.9	38.5	40.3	42.5	43.3	41.6	40.0	42.8
3. Made you more interested in trying drugs	4.0	3.0	3.3	3.6	2.9	2.7	2.8	2.8	2.5	2.8	2.9	2.3
N=	*1973*	*2004*	*2245*	*2006*	*1853*	*2163*	*2022*	*1921*	*1865*	*1953*	*1868*	*2010*
2E18. Overall, how valuable were the experiences to you?												
1. Little or no value	18.1	19.1	18.0	18.3	16.2	15.4	15.9	18.5	17.8	17.3	17.1	17.9
2. Some value	45.7	42.6	45.7	44.9	45.2	43.7	44.3	43.0	43.5	43.8	43.8	40.8
3. Considerable value	24.7	24.6	21.6	22.9	23.6	25.0	23.9	23.7	23.3	24.8	25.5	23.5
4. Great value	11.4	13.7	14.7	13.9	15.0	15.9	15.9	14.9	15.4	14.0	13.5	17.8
N=	*1985*	*1989*	*2237*	*1990*	*1829*	*2159*	*1999*	*1907*	*1857*	*1939*	*1854*	*1991*

Source: Monitoring the Future

Table 3

Exposure to Anti-Drug Commercials in the Media

(entries are in percentages)

	High school seniors in the class of: 1987
The next question asks about anti-drug comercials or "spots" that are intended to discourage drug use.	
4E11. In recent months, about how often have you seen such anti-drug commercials on TV, or heard them on the radio?	
1. Not at all	5.7
2. Less than once a month	6.9
3. 1-3 times per month	22.1
4. 1-3 times per week	29.3
5. Daily or almost daily	25.8
6. More than once a day	10.2
N=	*2726*

Source: Monitoring the Future

Table 4

Ratings of Anti-Drug Commercials in the Media

(entries are in percentages)

	High school seniors in the class of: 1987
4E12a. To what extent do you think such commercials have made people your age less favorable toward drugs?	
1. Not at all	22.3
2. To a little extent	32.8
3. To some extent	34.3
4. To a great extent	6.6
5. To a very great extent	4.0
N=	*2724*
4E12b. To what extent do you think such commercials have made you less favorable toward drugs?	
1. Not at all	25.5
2. To a little extent	19.9
3. To some extent	24.6
4. To a great extent	13.3
5. To a very great extent	16.5
N=	*2689*

Table 4 (cont'd)

		High school seniors in the class of: 1987
4E12c. To what extent do you think such commercials have made you less likely to use drugs?		
1. Not at all		27.5
2. To a little extent		17.8
3. To some extent		21.8
4. To a great extent		12.5
5. To a very great extent		20.4
	N=	*2681*
4E12d. To what extent do you think such commercials have overstated the dangers or risks of drug use?		
1. Not at all		48.8
2. To a little extent		16.4
3. To some extent		18.6
4. To a great extent		7.4
5. To a very great extent		8.8
	N=	*2693*

Source: Monitoring the Future

Table 5

Perceived Levels of Drug Use Among Public Role Models in 1987
(entries are in percentages)

4E09. These days, how many people in the following groups would you guess use illicit drugs (like marijuana, cocaine, etc.) occasionally or regularly?	Professional Athletes	Rock music performers	Actors and actresses
1. 0% to 10%	8.5	2.3	4.2
2. 11% to 30%	20.5	6.3	14.7
3. 31% to 50%	24.8	13.6	21.0
4. 51% to 70%	22.5	23.0	25.3
5. 71% to 90%	11.6	28.7	16.7
6. 91% to 100%	3.6	19.9	6.9
7. Have no idea	8.5	6.2	11.3
N=	*2797*	*2797*	*2795*

Source: Monitoring the Future

Table 6

Perceived Disapproval of Drug Use Among Public Role Models in 1987

(entries are in percentages)

4E10. How many people in the following groups would you guess strongly disapprove of such illicit drug use?

	Professional athletes	Rock music performers	Actors and actresses	People your age
1. 0% to 10%	9.7	24.4	12.5	11.7
2. 11% to 30%	25.9	28.6	25.0	20.9
3. 31% to 50%	22.0	17.3	22.6	24.4
4. 51% to 70%	14.8	11.5	14.6	19.8
5. 71% to 90%	11.3	4.4	7.2	10.0
6. 91% to 100%	4.7	2.5	3.4	3.7
7. Have no idea	11.6	11.2	14.7	9.4
N=	*2784*	*2774*	*2746*	*2770*

Source: Monitoring the Future

Table 7

Proportion of Seniors in 1987 Who Disapprove Strongly of Using Illicit Drugs Occasionally or Regularly

(entries are in percentages)

	Percent Who Strongly Disapprove
Smoking marijuana occasionally	45
Smoking marijuana regularly	67
Trying cocaine once or twice	70
Using cocaine regularly	86
Taking heroin occasionally	89
Taking heroin regularly	92
Taking barbituates regularly	78
Taking amphetamines regularly	77
Taking LSD regularly	88

Source: Monitoring the Future

Table 8

Receptiveness to Parent Groups Opposed to Drugs
(entries are in percentages)

	High school seniors in the class of:				
	1983	1984	1985	1986	1987*
4E09. In some communities parents who are particularly concerned with drug or alcohol abuse among young people have formed groups of concerned parents to deal with these problems. In these groups parents try to become more informed and sometimes to set some common guidelines for young peoples' behavior.					
In general, what do you think of the idea of having parents get together in groups such as these?					
1. A bad idea	6.4	6.6	5.1	5.1	--
2. More bad than good	7.1	7.9	6.1	8.1	--
3. Don't know or can't say	30.7	27.5	25.7	27.5	--
4. More good than bad	23.3	23.0	22.6	23.8	--
5. A good idea	32.5	35.1	40.4	35.5	--
N=	*2669*	*2659*	*2614*	*2600*	--

*Series dropped in 1987.

Source: Monitoring the Future

Table 9

Exposure to Parent Groups Opposed to Drugs
(entries are in percentages)

	High school seniors in the class of:				
	1983	1984	1985	1986	1987*
0. To the best of your knowledge, how many of r close friends have parents who are involved in h parent groups?					
1. None	73.0	70.5	70.0	69.1	--
2. A few	18.8	20.3	20.1	22.1	--
3. Some	7.3	8.2	9.4	8.0	--
4. Most or all	0.9	1.0	0.5	0.8	--
N=	*2656*	*2660*	*2599*	*2599*	--
l. Has either (or both) of your own parents involved in such a group?					
1. No	92.8	91.4	91.7	92.2	--
2. Yes, in the past, but not now	4.9	5.3	5.7	5.1	--
3. Yes, now	2.3	3.4	2.6	2.6	--
N=	*2595*	*2597*	*2558*	*2553*	--

ies dropped in 1987.

ce: Monitoring the Future

Table 10

Ratings of Parent Groups Opposed to Drugs
(entries are in percentages)

	High school seniors in the class of:				
	1983	1984	1985	1986	1987*
Asked only of those whose parent(s) had been in such groups					
4E12. Has the involvement of your parent(s) in such a group had any impact on your own feelings about drug or alcohol use?					
1. Made me much less likely to use drugs or alcohol	25.2	23.0	26.7	27.9	--
2. Made me somewhat less likely to use drugs or alcohol	12.7	15.7	16.4	16.9	--
3. No impact either way	56.5	52.9	53.0	49.3	--
4. Made me somewhat more likely to use drugs or alcohol	3.1	5.9	2.7	3.5	--
5. Made me much more likely to use drugs or alcohol	2.5	2.4	1.2	2.4	--
N=	*297*	*345*	*308*	*313*	--
4E13. What about your relationship with your parents? Has their involvement in the parent group made your relationship better or worse?					
1. Much worse	8.9	8.6	6.5	6.9	--
2. Somewhat worse	9.6	14.5	11.0	12.2	--
3. No effect, don't know	50.4	50.0	49.2	45.5	--
4. Somewhat better	13.9	10.9	20.4	20.7	--
5. Much better	17.3	16.0	13.0	14.8	--
N=	*287*	*340*	*314*	*306*	--

*Series dropped in 1987.

Source: Monitoring the Future

Table 11

Involvement in Teen Groups Opposed to Drugs

(entries are in percentages)

	High school seniors in the class of:				
	1983	1984	1985	1986	1987*
4E14. In some communities young people themselves have formed groups aimed at avoiding drug use, such as Youth for Drug-Free Alternatives. How many of your close friends have been members of such a group?					
1. None	87.5	81.9	77.5	69.6	--
2. A few	8.6	13.2	14.9	19.8	--
3. Some	3.1	4.2	6.8	9.3	--
4. Most or all	0.8	0.8	0.9	1.3	--
N=	*2651*	*2658*	*2605*	*2597*	--
4E15. Have you ever participated in such a group?					
3. Yes, now	1.6	3.2	3.7	5.2	--
2. Yes, in the past, but not now	3.3	4.4	5.4	6.9	--
1. No	95.1	92.4	90.8	88.0	--
N=	*2597*	*2616*	*2564*	*2540*	--

*Series dropped in 1987.

Source: Monitoring the Future

Answers to Senator Hatch's Questions
from Dr. Lloyd Johnston

Sen. Hatch. Dr. Johnston, if we took all the steps you advocate in your testimony, how long would it take to make a fairly substantial impact on [demand reduction in] the demand for drugs in this country?

Dr. Johnston. Of the various activities I have suggested, I would say that the mobilization of community leadership groups, and the building of models and guidelines for them, would be among the efforts having the most immediate impact. The creation of a Cabinet level position from which the leadership of these, and other drug control, activities might emanate would be another high payoff, rapid-turnaround possibility. In the end I believe that the President is the ultimate "drug czar," but he needs a high level person both to advise him and to carry out his policies in an integrated and thoughtful way.

I think the impact could be felt within two to three years and would cumulate thereafter.

Sen. Hatch. Given the current budgetary constraints, what would you say are the most cost-effective steps the federal government can take in the area of demand reduction?

Dr. Johnston. My answer is much the same, except that I would add the development and rapid evaluation of a host of additional intervention and prevention techniques--that is, funding "think tank" Prevention Development Centers as well as a greatly expanded prevention effort. I would also urge greater funding for research on the etiology and epidemiology of drug use, as an additional way of expanding the knowledge base. There is an urgent need for developing a methodology for quantifying, studying, and monitoring the size and nature of the drug epidemic in inner city areas--particularly in the out-of-school population.

Sen. Hatch. Do you think current drug treatment strategies are effective?

Dr. Johnston. Yes, I think they are effective; not as effective as we would like them to be, perhaps, but still effective at suppressing drug use and criminality during the period of treatment (or maintenance) and effective at getting a significant fraction of clients off of drugs and into a more productive lifestyle for the long term. In the era of AIDS I think we have no rational alternative than to make treatment available to intravenous drug users virtually on demand.

Sen. Hatch. If necessary, could resources be diverted from treatment to demand reduction programs?

Dr. Johnston. It may be rational in a fixed sum for demand-reduction situation to reallocate some treatment funds from treatment to prevention (particularly for research and development on programs). However, a far more rational strategy, in my opinion, would be to divert most additional funds for drug abuse control to the demand side or, if there are no additional funds to be allocated, to reallocate proportions between supply- and demand-reduction strategies, since the former are doomed to failure, in my opinion, while the latter are not.

Sen. Hatch. In your statement you note that shifting our resources towards demand reduction could pay off in the long run. Do you have any cost on the return from demand reduction efforts, that is how many cases of addiction can we prevent?

Dr. Johnston. First I would point out that it is not just addiction that we want to prevent: the great majority of drug users are not addicts, yet their behavior can be very dysfunctional for them, their families, and for society at large in that their aggregate demand constitutes a large portion of total demand. I am not aware of any systematic attempts to quantify the return per dollar invested in various demand reduction activities. What I am pretty sure is that it is higher than for supply reduction, where in the case of cocaine, I would judge the net return of our massive expenditures to be close to zero, if you leave aside seized assets. There is a glut of cocaine on the streets of America today.

Sen. Hatch. As I understand the High School Senior Survey, it does not measure those who are no longer in school. Is there a way, short of measuring the deaths and arrests of young adults, to determine what the level of use is among those who have dropped out of school?

Dr. Johnston. I believe that some methods can be developed. They will probably be expensive by social science standards, because of the difficulties involved in securing representative samples from this population, the high cost of the personal interviewing which would likely be needed, and the generally greater resistance in this segment of the population to being located and interviewed, which may make respondent payment necessary if an adequate response rate is to be achieved. Nevertheless, I am sure that some methods could be developed; and, given the alleged concentration of the most serious drug use in the inner city, out-of-school youth, I think that the costs of a monitoring system for this population probably are justified. Such work would fall within the purview of the NIDA Division of Epidemiology and Statistical Analysis.

Sen. Hatch. Is there a need for the development of one or more evaluation tools to be used by those in education and prevention?

Dr. Johnston. If by tools you mean standard questionnaires, I am not sure that is so critical, although I should mention that some such studies do use the High School Senior Survey Questionnaire to permit a comparison with their results with the national results. Careful research designs, with before-and-after measurement of use, attitudes, and other factors are important, as are adequate randomly matched comparison groups. This is a fairly sophisticated type of research and should definitely be conducted by trained scientists using research designs which are put in place in advance of the demonstration efforts, not cobbled together after the fact. I would say that the major flaw in the functioning of the Office of Substance Abuse Prevention within ADAMHA is that comparable monies to those spent on program development are not being allocated to program evaluation. If we do not do the evaluation, we will never know what worked and what did not. This is an issue, I discuss at more length in a recent policy paper commissioned by the Department of Education. I make it available for inclusion in the record, Mr. Chairman.

Sen. Hatch. I have been told that one of the big problems is among those adults who came to maturity during the 60s and 70s. How can we reach this population? It seems to me that it is important to reach them because they are the role models for many of today's children.

Dr. Johnston. Certainly, Senator Hatch, there is a tendency for generations to tend to carry along with them through the life cycle some of the substance using behaviors they learned as adolescents: nowhere is this more evident than in the case of cigarettes. But a good number of people also give up some of the risk-taking behavior patterns they exhibited in adolescence--for example, delinquency falls sharply in the twenties--and this also seems to happen to a considerable degree for various forms of illicit drug use. Marriage, for one, seems to have a sobering effect, as does raising their own children, I suspect. In general, I think that as perceptions of the risk of drug use go up among adolescents, they will change in a similar way among those in their twenties and thirties. Also, to the extent that social norms change, they should influence older age groups, as well. Many in the 60's and 70's became involved with drugs as part of a social movement--the anti-Vietnam War movement. Since that movement no longer is a salient cause, I think much of the impetus has declined. Nevertheless, I think people in their adult years can be effectively approached and influenced in terms of their role modeling for their own children, their responsibilities to their co-workers, and their responsibilities as constructive citizens in the world's greatest and most influential democracy.

The University of Michigan

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January 12, 1988 (10)
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Illicit drug use by American high school seniors, college students and young adults continued to decline in 1987, but U-M researchers say U.S. usage still highest in industrialized world.

FOR RELEASE 9:30 A.M. WEDNESDAY JANUARY 13, 1988

EDITORS: Details of annual drug survey are in attached statement.

WASHINGTON, D.C.---The first substantial decline in cocaine use among American high school seniors, college students and young adults was detected in the 1987 drug survey conducted by researchers at The University of Michigan's Institute for Social Research (ISR).

Social psychologists Lloyd D. Johnston, Jerald G. Bachman and Patrick M. O'Malley cautioned that although overall drug usage among young people continued a trend of gradual decline last year, the United States still has the highest rates among the world's industrialized nations.

Even with the modest improvement in the cocaine situation and other cooling of what they call "the unhealthy romance between many of America's young people and illicit drugs," the U-M researchers insist that "we have come only part way down from a very high mountain, and to a considerable degree that is true of the drug problem in general."

Over half (57 percent) of last year's high school seniors still had tried an illicit drug, and over a third had tried an illicit drug other than marijuana.

The survey found little change in the use of LSD, heroin or other opiates, and there was some evidence of a continuing gradual increase in the use of inhalants.

The use of alcohol was little changed and cigarette smoking---which the researchers say will take the lives of more young people than all other drugs combined---has not dropped among high school seniors since 1984.

##########

(ISR;Johnston;Bachman;O'Malley)(R1a/R1b/R2a/R2b/R3/ISRa/ISRb/ISRc/RTspa/RTspb/Ed1/Ed2a/Ed2b/Ed3/X1a/X2a/X9/)[0481]

SUMMARY OF 1987 DRUG STUDY RESULTS

(MEDIA STATEMENT delivered by Dr. Lloyd D. Johnston of The University of Michigan at a national news conference in the Washington, D.C offices of the Secretary of Health and Human Services, made in conjunction with a statement by HHS Secretary Otis Bowen, 9:30 a.m. Wednesday, January 13, 1988.)

* * * * * * * *

We are pleased to be able to report that the unhealthy romance between many of America's young people and illicit drugs continued to cool in 1987.

Clearly the most important part of the story is that, for the first time in eight years, cocaine showed a significant drop in use. Cocaine---one of the most seductive of the illicit drugs, one of the most dangerous, one of the most addicting---has also been among the most widely used by American young people.

In recent years cocaine ranked second only to marijuana in active use among both high school seniors and young adults. In fact, the proportion of high school graduates reporting some experience with cocaine by age 27 reached as high as 40 percent. After it had remained at peak levels in these age groups for seven years, there occurred in 1987 a drop of about one-fifth in the annual usage statistics observed among American high school students, American college students, and young adults generally.

It also appears that the worrisome crack epidemic of 1986, which had seemed poised to explode into a much greater health menace, leveled out by 1987---at least among these populations. Unfortunately we do not have measures for the 15-20 percent of an age group who do not finish high school. Certainly in some cities the crack epidemic is particularly serious in this part of the population.

What does all of this mean in terms of numbers? It still means that about one in every six or seven high school seniors has tried co[illegible]ne (15.2%) and one in 18 (5.6%) has tried crack cocaine specifically. Among high school graduates in their late twenties today, it means that nearly four in 10 (39%) have tried cocaine and one in 15 (6.7%) has tried crack specifically.

These findings all derive from the 13th annual survey in this series, entitled Monitoring the Future. The study is conducted by The University of Michigan's Institute for Social Research by three social psychologists---Lloyd D. Johnston, Jerald G. Bachman, and Patrick M. O'Malley---and is funded by the National Institute on Drug Abuse.

Like all of the previous surveys in the series, this one has a nationally representative sample of some 16,000 seniors in about 130 public and private high schools nationwide. We are also reporting on results of the 1987 follow-up survey of approximately 10,000 graduates from the classes of 1975 through 1986. The follow-up surveys, which are conducted by mail, yield a nationally representative sample of all high school graduates aged 19 to 29 including college students. (The study has contained a national sample of about 1,100 college students each year since 1980.) Thus, today we will be discussing trends for American high school students, college students, and young adults generally up to age 29.

America's drug epidemic is, in fact, composed of many drug-specific epidemics, and these have not all risen and fallen in unison. During the early 1970s the use of most illicit drugs was rising among America's young people. But by the mid-seventies, some---like nonmedical use of tranquilizers and barbiturates---began what was to be a long and gradual decline in use. Others reached their peak levels in subsequent years and then began to decline as well, including: marijuana in 1978; PCP in 1979; LSD in 1980; and amphetamines in 1982.

But it was not until 1987 when the latest and perhaps most troublesome drug---cocaine---gave evidence of beginning to turn downward.

The cocaine epidemic has been particularly troublesome for two reasons. First, cocaine has proven to be highly addictive, and otherwise dangerous for the user. In fact, it has become appreciably more addictive and dangerous with the emergence of crack in the last couple of years. Second, a great many young Americans have been putting themselves at risk by trying cocaine---up to 40 percent of young people reaching their late twenties in the past few years have tried cocaine.

After increasing sharply in popularity among young adults and adolescents in the latter half of the seventies, cocaine use remained relatively stable in these age groups for the next seven years (1979-86); and this was despite expanded efforts at all levels of government to cut off the supply of the drug. (See attached figure.) The increase in availability and drop in price during the period surely helped sustain the epidemic; and they certainly helped to demonstrate that supply control efforts alone are not enough to control a drug epidemic. Demand must be reduced or the lure of great profits simply continues to attract new suppliers.

In 1987 we observed the first drop in demand for cocaine among adolescents and young adults. For example, the number of high school seniors reporting cocaine use in the year prior to the survey fell by one-fifth between 1986 and 1987 (from 12.7% to 10.3%). The same occurred among American young adults (high school graduates) aged 19 to 29---in this case a drop from 20 to 16 percent. Among college students specifically, the drop was from 17 to 14 percent. In all cases, these changes are statistically significant.

This turnround may have a number of determinants, but certainly one has been a dramatic increase in the number of young people who believe that using the drug, even experimentally, is dangerous. Among high school seniors, for example, the number who saw "great risk" associated with trying cocaine once or twice jumped from 34 percent in 1986 to 48 percent in 1987. The corresponding one-year shift in regard to the dangers of occasional use was from 54 to 67 percent.

For a full eight years prior to 1986, there had been virtually no change in the perceived risks of experimenting with cocaine, so this shift was a sudden and dramatic one. Undoubtedly the tragic deaths from cocaine use of sports stars Len Bias and Don Rogers served to get the attention of many young Americans. The message was clear: no one is invincible, not even those who would seem the most likely to be.

But much more was happening during this historical period. The media and many national leaders were drawing public attention to the drug problem and to the hazards of drugs, particularly crack. And these events, in combination, appeared to make an impression on our young people. There was an increase across all of the illegal drugs in the proportions of seniors who see them as carrying great risks for their users.

Personal attitudes and peer norms are changing as well, with a significant increase for every illicit drug in the proportion of seniors who say they disapprove of its use. In fact, in 1987, 87 percent of seniors disapproved of even trying cocaine, a 7 percent jump in one year. Fully 97 percent disapprove of regular cocaine use.

Why do we think that the downturn in cocaine use represents a change in demand? Well, first, we have seen that the fundamental beliefs and attitudes among young Americans about this drug have changed appreciably. But, second, there has been no downturn in the perceived availability of cocaine by seniors; if anything, it is perceived as more available in the last couple of years. Further, we know from DEA figures that, in general, the price has dropped and purity has risen in the 1980s. None of these facts would suggest a reduced supply; therefore it must be the demand which has declined.

Ever since 1978 we have been reporting a decline in marijuana use---indeed, a very appreciable one in terms of daily use---and it appears that much or all of that change reflected a drop in demand as well. In fact, the proportion of seniors who felt that regular marijuana use carried a great risk more than doubled, from 35 to 74 percent, as actual daily use fell by more than two-thirds (from 10.7% in 1978 to 3.3% in 1987). As with cocaine, there was practically no decrease in the perceived availability of marijuana over that interval.

Our evidence on trends in crack use is more inferential than for all other drugs, because we have not had questions about it for as many years. But from the data we have on the proportion of seniors smoking cocaine---which is what most crack users report as their mode of ingestion---we have seen evidence of a rapid spread in crack use between 1983 and 1986. In 1987 there was a slight decline in this statistic for the first time, suggesting either a leveling or slight decline in the use of crack.

We also looked to see how widely crack had spread from the very large cities to other communities. Last year we reported that half of the schools in the sample had evidence of crack having been used by at least some of their students. In 1987 the proportion rose to 75 percent of all schools. Clearly there has been a rapid diffusion of this drug, but we believe that the very extensive media coverage of its hazards helped to put a cap on this epidemic far more quickly than we have seen for any of the other drugs.

To summarize the "good news" part of the story, we have found continuing declines in 1987 in the use of marijuana, stimulants, sedatives, and methaqualone specifically, in all three populations---high school seniors, college students, and young adults generally. Most importantly, we have seen the first substantial decline in cocaine use in these populations. Changing attitudes about the hazards of these drugs and changing norms appear to have played an important role in the declines.

Despite the good news, I want to conclude on a cautionary note. First, there was little change observed in the use of LSD, heroin or opiates other than heroin; and there was some evidence of a continuing gradual increase in the use of inhalants. Second, the improvement in the cocaine situation is modest. We have come only part way down from a very high mountain, and to a considerable degree that is true of the drug problem in general.

Over half (57%) of last year's seniors still have tried an illicit drug, and over a third (36%) have tried an illicit drug other than marijuana. Four in every 10 (42%) had used an illicit drug in just the past year and one quarter (24%) used something other than marijuana.

These clearly remain the highest rates of illicit drug use of any country in the industrialized world. And as our long parade of popular drugs suggests, there likely will be more to come. This means that we must be consistent and sustained in our efforts both to lower these rates and to prepare our young people to deal with new drug problems as they arise.

Finally, regarding the important licit drugs covered in the study, we have seen no further decline in the use of alcohol in the past three years, although there had been some drop for several prior years. Nearly all high school seniors (92%) have had experience with alcohol and two-thirds (66%) are current users (i.e., have used in the past 30 days). About 5 percent are daily drinkers and most important, perhaps, is that nearly 40 percent (37.5%) percent report at least one occasion of heavy drinking in the past two weeks---that is, an occasion in which they had five or more drinks in a row. None of these figures has shown any improvement in the past three years.

Cigarette smoking---the substance-using behavior that will take the lives of more of these young people than all of the others combined---has not dropped among high school seniors since 1984. Nearly a fifth (18.7%) of them are already daily smokers by the time they leave high school and more will convert from occasional to regular smoking in the years following high school. (Note that these statistics do not include high school dropouts, the majority of whom smoke.)

Most of these young people begin smoking by age 13, and their pattern of smoking in adolescence is highly predictive of their smoking behavior throughout adulthood. I think we need to ask why, in an era in which the hazards of smoking are widely recognized and the norms regarding smoking are continuing to become more negative, the smoking rate among our young people is not falling. It is an important question, with literally hundreds of thousands of our children's lives hanging in the balance.

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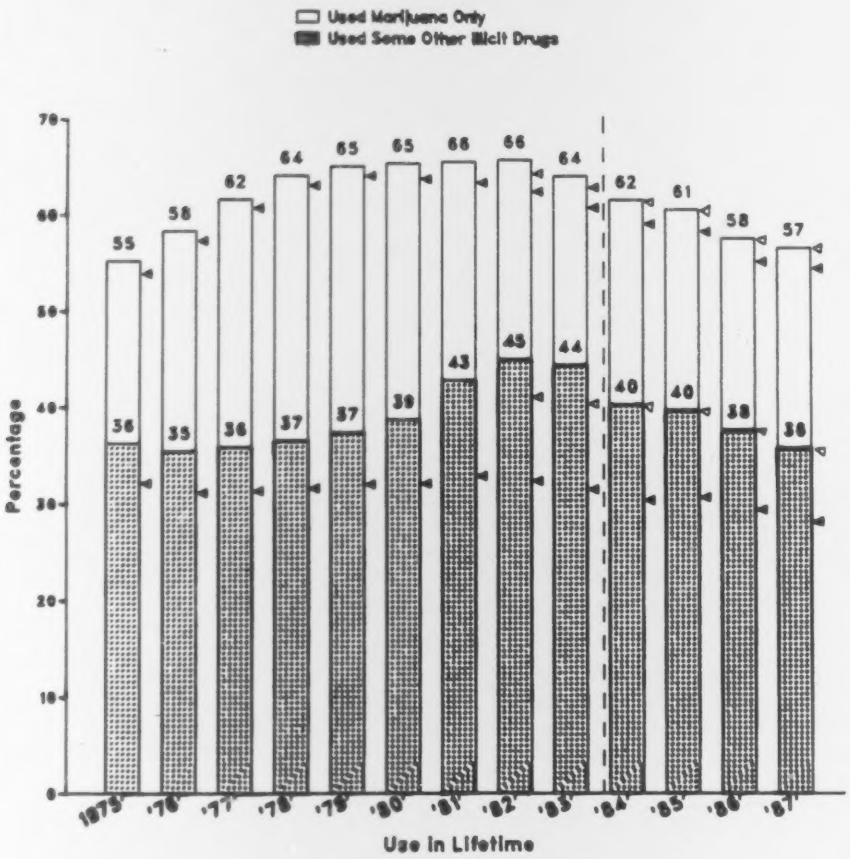
NOTE: The following tables and figures are taken from the following monograph, now in preparation, which will be published later this year by the National Institute on Drug Abuse: Johnston, L.D., O'Malley, P.M., and Bachman, J.G. "Illicit Drug Use, Smoking, and Drinking by America's High School Students, College Students, and Young Adults, 1975-1987."

FIGURE 1

Trends in Lifetime Prevalence of an Illicit Drug Use Index

All Seniors



NOTES: Use of "some other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use which is not under a doctor's orders of other opiates, stimulants, sedatives, or tranquilizers.

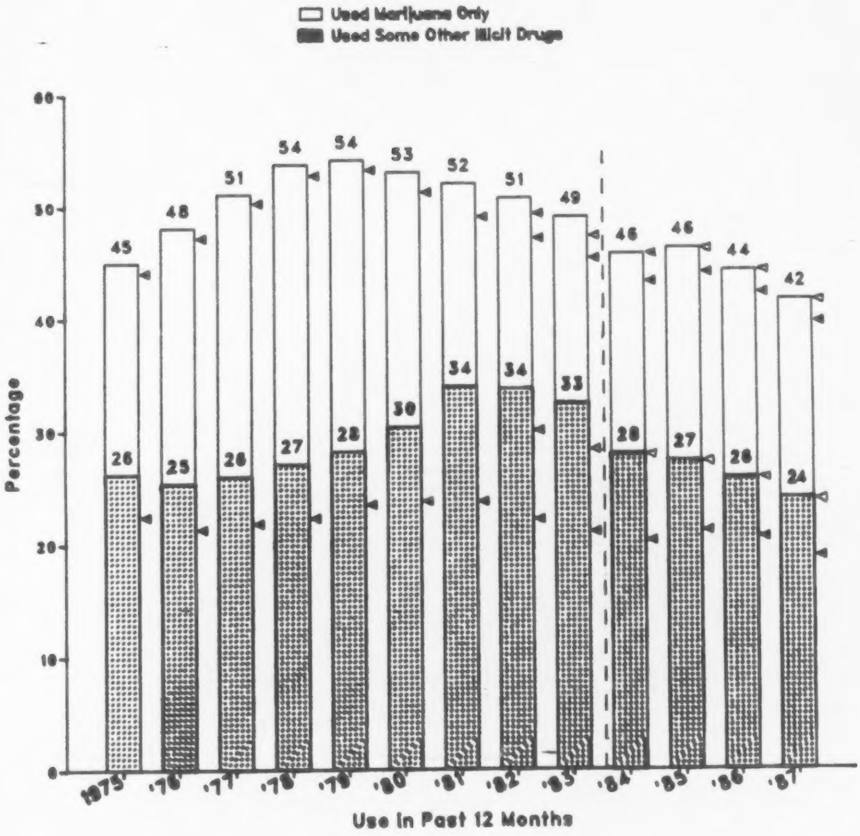
◄ indicates the percentage which results if all stimulants are excluded from the definition of "illicit drugs." ◁ shows the percentage which results if only non-prescription stimulants are excluded.

The dashed vertical line indicates that after 1983 the shaded and open bars are defined by using the amphetamine questions which were revised to exclude non-prescription stimulants from the definition of "illicit drugs."

FIGURE 2

Trends in Annual Prevalence of an Illicit Drug Use Index

All Seniors



NOTES: Use of "some other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use which is not under a doctor's orders of other opiates, stimulants, sedatives, or tranquilizers.

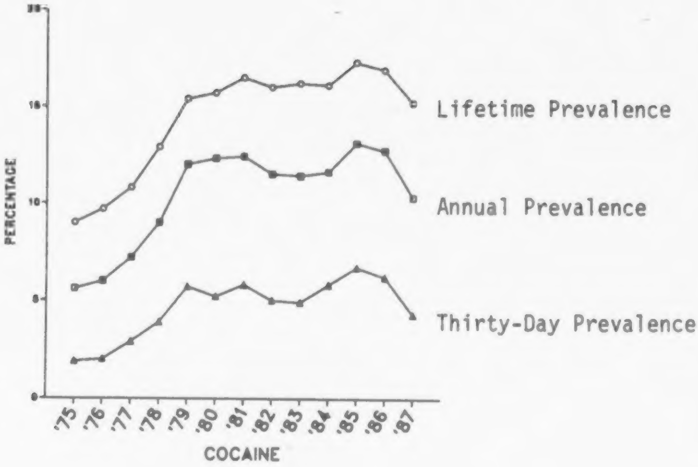
◄ indicates the percentage which results if all stimulants are excluded from the definition of "illicit drugs." ◁ shows the percentage which results if only non-prescription stimulants are excluded.

The dashed vertical line indicates that after 1983 the shaded and open bars are defined by using the amphetamine questions which were revised to exclude non-prescription stimulants from the definition of "illicit drugs."

FIGURE 3

Trends in Lifetime, Annual, and Thirty-Day Prevalence of Cocaine

All Seniors



Trends in Lifetime, Annual, and Thirty-Day Prevalence of Cocaine
All Seniors

	'75	'76	'77	'78	'79	'80	'81	'82	'83	'84	'85	'86	'87
Lifetime	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1	17.3	16.9	15.2
Annual	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3
Thirty-Day	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3

TABLE 7
Trends in Lifetime Prevalence of Sixteen Types of Drugs

	Percent ever used													
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86–'87 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	
Marijuana/Hashish	47.3	52.8	56.4	59.2	60.4	60.3	59.5	58.7	57.0	54.9	54.2	50.9	50.2	−0.7
Inhalants[a]	NA	10.3	11.1	12.0	12.7	11.9	12.3	12.8	13.6	14.4	15.4	15.9	17.0	+1.1
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*18.2*	*17.3*	*17.2*	*17.7*	*18.2*	*18.0*	*18.1*	*20.1*	*18.6*	*−1.5*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	11.1	11.1	10.1	9.8	8.4	8.1	7.9	8.6	4.7	−3.9sss
Hallucinogens	16.3	15.1	13.9	14.3	14.1	13.3	13.3	12.5	11.9	10.7	10.3	9.7	10.3	+0.6
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*17.7*	*15.6*	*15.3*	*14.3*	*13.6*	*12.3*	*12.1*	*11.9*	*10.6*	*−1.3s*
LSD	11.3	11.0	9.8	9.7	9.5	9.3	9.8	9.6	8.9	8.0	7.5	7.2	8.4	+1.2s
PCP[c,h]	NA	NA	NA	NA	12.8	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0	−1.8ss
Cocaine	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1	17.3	16.9	15.2	−1.7s
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.6	NA
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14.0	NA
Heroin	2.2	1.8	1.8	1.6	1.1	1.1	1.1	1.2	1.2	1.3	1.2	1.1	1.2	+0.1
Other opiates[e]	9.0	9.6	10.3	9.9	10.1	9.8	10.1	9.6	9.4	9.7	10.2	9.0	9.2	+0.2
Stimulants[e]	22.3	22.6	23.0	22.9	24.2	26.4	32.2	35.6	35.4	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*27.9*	*26.9*	*27.9*	*26.2*	*23.4*	*21.6*	*−1.8s*
Sedatives[e]	18.2	17.7	17.4	16.0	14.6	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7	−1.7ss
Barbiturates[e]	16.9	16.2	15.6	13.7	11.8	11.0	11.3	10.3	9.9	9.9	9.2	8.4	7.4	−1.0
Methaqualone[e]	8.1	7.8	8.5	7.9	8.3	9.5	10.6	10.7	10.1	8.3	6.7	5.2	4.0	−1.2ss
Tranquilizers[e]	17.0	16.8	18.0	17.0	16.3	15.2	14.7	14.0	13.3	12.4	11.9	10.9	10.9	0.0
Alcohol	90.4	91.9	92.5	93.1	93.0	93.2	92.6	92.8	92.6	92.6	92.2	91.3	92.2	+0.9
Cigarettes	73.6	75.4	75.7	75.3	74.0	71.0	71.0	70.1	70.6	69.7	68.8	67.6	67.2	−0.4

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-fifth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

[e] Only drug use which was not under a doctor's orders is included here.

[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[g] Data based on two questionnaire forms. N is two-fifths of N indicated.

[h] Question text changed slightly in 1987.

TABLE 8
Trends in Annual Prevalence of Seventeen Types of Drugs

	Percent who used in last twelve months													
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86–'87 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	
Marijuana/Hashish	40.0	44.5	47.6	50.2	50.8	48.8	46.1	44.3	42.3	40.0	40.6	38.8	36.3	−2.5s
Inhalants[a]	NA	3.0	3.7	4.1	5.4	4.6	4.1	4.5	4.3	5.1	5.7	6.1	6.9	+0.8
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*8.9*	*7.9*	*6.1*	*6.6*	*6.2*	*7.2*	*7.5*	*8.9*	*8.1*	*−0.8*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	6.5	5.7	3.7	3.6	3.6	4.0	4.0	4.7	2.6	−2.1sss
Hallucinogens	11.2	9.4	8.8	9.6	9.9	9.3	9.0	8.1	7.3	6.5	6.3	6.0	6.4	+0.4
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*11.8*	*10.4*	*10.1*	*9.0*	*8.3*	*7.3*	*7.6*	*7.6*	*6.7*	*−0.9*
LSD	7.2	6.4	5.5	6.3	6.6	6.5	6.5	6.1	5.4	4.7	4.4	4.5	5.2	+0.7
PCP[c,h]	NA	NA	NA	NA	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3	−1.1ss
Cocaine	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3	−2.4sss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.0	NA
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	9.8	NA
Heroin	1.0	0.8	0.8	0.8	0.5	0.5	0.5	0.6	0.6	0.5	0.6	0.5	0.5	0.0
Other opiates[e]	5.7	5.7	6.4	6.0	6.2	6.3	5.9	5.3	5.1	5.2	5.9	5.2	5.3	+0.1
Stimulants[e]	16.2	15.8	16.3	17.1	18.3	20.8	26.0	26.1	24.6	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*20.3*	*17.9*	*17.7*	*15.8*	*13.4*	*12.2*	*−1.2*
Sedatives[e]	11.7	10.7	10.8	9.9	9.9	10.3	10.5	9.1	7.9	6.6	5.8	5.2	4.1	−1.1ss
Barbiturates[e]	10.7	9.6	9.3	8.1	7.5	6.8	6.6	5.5	5.2	4.9	4.6	4.2	3.6	−0.6
Methaqualone[e]	5.1	4.7	5.2	4.9	5.9	7.2	7.6	6.8	5.4	3.8	2.8	2.1	1.5	−0.6s
Tranquilizers[e]	10.6	10.3	10.8	9.9	9.6	8.7	8.0	7.0	6.9	6.1	6.1	5.8	5.5	−0.3
Alcohol	84.8	85.7	87.0	87.7	88.1	87.9	87.0	86.8	87.3	86.0	85.6	84.5	85.7	+1.2
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-fifth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

[e] Only drug use which was not under a doctor's orders is included here.

[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[g] Data based on two questionnaire forms. N is two-fifths of N indicated.

[h] Question text changed slightly in 1987.

TABLE 9
Trends in Thirty-Day Prevalence of Sixteen Types of Drugs

	Percent who used in last thirty days													
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86–'87 change
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	
Marijuana/Hashish	27.1	32.2	35.4	37.1	36.5	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0	−2.4s
Inhalants[a]	NA	0.9	1.3	1.5	1.7	1.4	1.5	1.5	1.7	1.9	2.2	2.5	2.8	+0.3
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*3.2*	*2.7*	*2.5*	*2.5*	*2.5*	*2.6*	*3.0*	*3.2*	*3.5*	*+0.3*
Amyl & Butyl Nitrites[c,h]	NA	NA	NA	NA	2.4	1.8	1.4	1.1	1.4	1.4	1.6	1.3	1.3	0.0
Hallucinogens	4.7	3.4	4.1	3.9	4.0	3.7	3.7	3.4	2.8	2.6	2.5	2.5	2.5	0.0
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*5.3*	*4.4*	*4.5*	*4.1*	*3.5*	*3.2*	*3.8*	*3.5*	*2.8*	*−0.7*
LSD	2.3	1.9	2.1	2.1	2.4	2.3	2.5	2.4	1.9	1.5	1.6	1.7	1.8	+0.1
PCP[c,h]	NA	NA	NA	NA	2.4	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6	−0.7s
Cocaine	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3	−1.9sss
"Crack"[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.5	NA
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	NA
Heroin	0.4	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.0
Other opiates[e]	2.1	2.0	2.8	2.1	2.4	2.4	2.1	1.8	1.8	1.8	2.3	2.0	1.8	−0.2
Stimulants[e]	8.5	7.7	8.8	8.7	9.9	12.1	15.8	13.7	12.4	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*10.7*	*8.9*	*8.3*	*6.8*	*5.5*	*5.2*	*−0.3*
Sedatives[e]	5.4	4.5	5.1	4.2	4.4	4.8	4.6	3.4	3.0	2.3	2.4	2.2	1.7	−0.5s
Barbiturates[e]	4.7	3.9	4.3	3.2	3.2	2.9	2.6	2.0	2.1	1.7	2.0	1.8	1.4	−0.4
Methaqualone[e]	2.1	1.6	2.3	1.9	2.3	3.3	3.1	2.4	1.8	1.1	1.0	0.8	0.6	−0.2
Tranquilizers[e]	4.1	4.0	4.6	3.4	3.7	3.1	2.7	2.4	2.5	2.1	2.1	2.1	2.0	−0.1
Alcohol	68.2	68.3	71.2	72.1	71.8	72.0	70.7	69.7	69.4	67.2	65.9	65.3	66.4	+1.1
Cigarettes	36.7	38.8	38.4	36.7	34.4	30.5	29.4	30.0	30.3	29.3	30.1	29.6	29.4	−0.2

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-fifth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

[e] Only drug use which was not under a doctor's orders is included here.

[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[g] Data based on two questionnaire forms. N is two-fifths of N indicated.

[h] Question text changed slightly in 1987.

TABLE 10
Trends in Thirty-Day Prevalence of Daily Use of Sixteen Types of Drugs

	Percent who used daily in last thirty days													
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86–'87 change[g]
Approx. N =	(9400)	(15400)	(17100)	(17800)	(15500)	(15900)	(17500)	(17700)	(16300)	(15900)	(16000)	(15200)	(16300)	
Marijuana/Hashish	6.0	8.2	9.1	10.7	10.3	9.1	7.0	6.3	5.5	5.0	4.9	4.0	3.3	−0.7s
Inhalants[a]	NA	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	−0.1
Inhalants Adjusted[b]	*NA*	*NA*	*NA*	*NA*	*0.1*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.4*	*0.4*	*0.4*	*0.0*
Amyl & Butyl Nitrites[c,i]	NA	NA	NA	NA	0.0	0.1	0.1	0.0	0.2	0.1	0.3	0.5	0.3	−0.2
Hallucinogens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Hallucinogens Adjusted[d]	*NA*	*NA*	*NA*	*NA*	*0.2*	*0.2*	*0.1*	*0.2*	*0.2*	*0.2*	*0.3*	*0.3*	*0.2*	*−0.1*
LSD	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0
PCP[c,i]	NA	NA	NA	NA	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3	+0.1
Cocaine	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.4	0.4	0.3	−0.2[g]
"Crack"[h]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	NA
Other cocaine[c]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.2	NA
Heroin	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Other opiates[e]	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
Stimulants[e]	0.5	0.4	0.5	0.5	0.6	0.7	1.2	1.1	1.1	NA	NA	NA	NA	NA
Stimulants Adjusted[e,f]	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*0.7*	*0.8*	*0.6*	*0.4*	*0.3*	*0.3*	*0.0*
Sedatives[e]	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.0
Barbiturates[e]	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.0
Methaqualone[e]	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Tranquilizers[e]	0.1	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.0
Alcohol														
Daily	5.7	5.6	6.1	5.7	6.9	6.0	6.0	5.7	5.5	4.8	5.0	4.8	4.8	0.0
5+ drinks in a row/ last 2 weeks	36.8	37.1	39.4	40.3	41.2	41.2	41.4	40.5	40.8	38.7	36.7	36.8	37.5	+0.7
Cigarettes	26.9	28.8	28.8	27.5	25.4	21.3	20.3	21.1	21.2	18.7	19.5	18.7	18.7	0.0

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. NA indicates data not available.

[a] Data based on four questionnaire forms. N is four-fifths of N indicated.

[b] Adjusted for underreporting of amyl and butyl nitrites. See text for details.

[c] Data based on a single questionnaire form. N is one-fifth of N indicated.

[d] Adjusted for underreporting of PCP. See text for details.

[e] Only drug use which was not under a doctor's orders is included here.

[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

[g] Any apparent inconsistency between the change estimate and the prevalence estimates for the two most recent classes is due to rounding error.

[h] Data based on two questionnaire forms. N is two-fifths of N indicated.

[i] Question text changed slightly in 1987.

TABLE 15

Trends in Perceived Harmfulness of Drugs

	Percentage saying "great risk"[a]													
Q. How much do you think people risk harming themselves (physically or in other ways), if they . . .	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86–'87 change
Try marijuana once or twice	15.1	11.4	9.5	8.1	9.4	10.0	13.0	11.5	12.7	14.7	14.8	15.1	18.4	+3.3ss
Smoke marijuana occasionally	18.1	15.0	13.4	12.4	13.5	14.7	19.1	18.3	20.6	22.6	24.5	25.0	30.4	+5.4sss
Smoke marijuana regularly	43.3	38.6	36.4	34.9	42.0	50.4	57.6	60.4	62.8	66.9	70.4	71.3	73.5	+2.2
Try LSD once or twice	49.4	45.7	43.2	42.7	41.6	43.9	45.5	44.9	44.7	45.4	43.5	42.0	44.9	+2.9
Take LSD regularly	81.4	80.8	79.1	81.1	82.4	83.0	83.5	83.5	83.2	83.8	82.9	82.6	83.8	+1.2
Try PCP once or twice	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	55.6	NA
Try cocaine once or twice	42.6	39.1	35.6	33.2	31.5	31.3	32.1	32.8	33.0	35.7	34.0	33.5	47.9	+14.4sss
Take cocaine occasionally	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	54.2	66.8	+12.6sss
Take cocaine regularly	73.1	72.3	68.2	68.2	69.5	69.2	71.2	73.0	74.3	78.8	79.0	82.2	88.5	+6.3sss
Try heroin once or twice	60.1	58.9	55.8	52.9	50.4	52.1	52.9	51.1	50.8	49.8	47.3	45.8	53.6	+7.8sss
Take heroin occasionally	75.6	75.6	71.9	71.4	70.9	70.9	72.2	69.8	71.8	70.7	69.8	68.2	74.6	+6.4sss
Take heroin regularly	87.2	88.6	86.1	86.6	87.5	86.2	87.5	86.0	86.1	87.2	86.0	87.1	88.7	+1.6
Try amphetamines once or twice	35.4	33.4	30.8	29.9	29.7	29.7	26.4	25.3	24.7	25.4	25.2	25.1	29.1	+4.0ss
Take amphetamines regularly	69.0	67.3	66.6	67.1	69.9	69.1	66.1	64.7	64.8	67.1	67.2	67.3	69.4	+2.1
Try barbiturates once or twice	34.8	32.5	31.2	31.3	30.7	30.9	28.4	27.5	27.0	27.4	26.1	25.4	30.9	+5.5sss
Take barbiturates regularly	69.1	67.7	68.6	68.4	71.6	72.2	69.9	67.6	67.7	68.5	68.3	67.2	69.4	+2.2
Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	5.3	4.8	4.1	3.4	4.1	3.8	4.6	3.5	4.2	4.6	5.0	4.6	6.2	+1.6s
Take one or two drinks nearly every day	21.5	21.2	18.5	19.6	22.6	20.3	21.6	21.6	21.6	23.0	24.4	25.1	26.2	+1.1
Take four or five drinks nearly every day	63.5	61.0	62.9	63.1	66.2	65.7	64.5	65.5	66.8	68.4	69.8	66.5	69.7	+3.2s
Have five or more drinks once or twice each weekend	37.8	37.0	34.7	34.5	34.9	35.9	36.3	36.0	38.6	41.7	43.0	39.1	41.9	+2.8
Smoke one or more packs of cigarettes per day	51.3	56.4	58.4	59.0	63.0	63.7	63.3	60.5	61.2	63.8	66.5	66.0	68.6	+2.6
Approx. N =	(2804)	(2918)	(3052)	(3770)	(3250)	(3234)	(3604)	(3557)	(3305)	(3262)	(3250)	(3020)	(3315)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.

[a] Answer alternatives were: (1) No risk, (2) Slight risk, (3) Moderate risk, (4) Great risk, and (5) Can't say, drug unfamiliar.

TABLE 16
Trends in Proportions Disapproving of Drug Use

Q. Do you disapprove of people (who are 18 or older) doing each of the following?[b]	Percentage "disapproving"[a]													
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86–'87 change
Try marijuana once or twice	47.0	38.4	33.4	33.4	34.2	39.0	40.0	45.5	46.3	49.3	51.4	54.6	56.6	+2.0
Smoke marijuana occasionally	54.8	47.8	44.3	43.5	45.3	49.7	52.6	59.1	60.7	63.5	65.8	69.0	71.6	+2.6
Smoke marijuana regularly	71.9	69.5	65.5	67.5	69.2	74.6	77.4	80.6	82.5	84.7	85.5	86.6	89.2	+2.6s
Try LSD once or twice	82.8	84.6	83.9	85.4	86.6	87.3	86.4	88.8	89.1	88.9	89.5	89.2	91.6	+2.4ss
Take LSD regularly	94.1	95.3	95.8	96.4	96.9	96.7	96.8	96.7	97.0	96.8	97.0	96.6	97.8	+1.2s
Try cocaine once or twice	81.3	82.4	79.1	77.0	74.7	76.3	74.6	76.6	77.0	79.7	79.3	80.2	87.3	+7.1sss
Take cocaine regularly	93.3	93.9	92.1	91.9	90.8	91.1	90.7	91.5	93.2	94.5	93.8	94.3	96.7	+2.4sss
Try heroin once or twice	91.5	92.6	92.5	92.0	93.4	93.5	93.5	94.6	94.3	94.0	94.0	93.3	96.2	+2.9sss
Take heroin occasionally	94.8	96.0	96.0	96.4	96.8	96.7	97.2	96.9	96.9	97.1	96.8	96.6	97.9	+1.3s
Take heroin regularly	96.7	97.5	97.2	97.8	97.9	97.6	97.8	97.5	97.7	98.0	97.6	97.6	98.1	+0.5
Try amphetamines once or twice	74.8	75.1	74.2	74.8	75.1	75.4	71.1	72.6	72.3	72.8	74.9	76.5	80.7	+4.2ss
Take amphetamines regularly	92.1	92.8	92.5	93.5	94.4	93.0	91.7	92.0	92.6	93.6	93.3	93.5	95.4	+1.9ss
Try barbiturates once or twice	77.7	81.3	81.1	82.4	84.0	83.9	82.4	84.4	83.1	84.1	84.9	86.8	89.6	+2.8ss
Take barbiturates regularly	93.3	93.6	93.0	94.3	95.2	95.4	94.2	94.4	95.1	95.1	95.5	94.9	96.4	+1.5s
Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	21.6	18.2	15.6	15.6	15.8	16.0	17.2	18.2	18.4	17.4	20.3	20.9	21.4	+0.5
Take one or two drinks nearly every day	67.6	68.9	66.8	67.7	68.3	69.0	69.1	69.9	68.9	72.9	70.9	72.8	74.2	+1.4
Take four or five drinks nearly every day	88.7	90.7	88.4	90.2	91.7	90.8	91.8	90.9	90.0	91.0	92.0	91.4	92.2	+0.8
Have five or more drinks once or twice each weekend	60.3	58.6	57.4	56.2	56.7	55.6	55.5	58.8	56.6	59.6	60.4	62.4	62.0	−0.4
Smoke one or more packs of cigarettes per day	67.5	65.9	66.4	67.0	70.3	70.8	69.9	69.4	70.8	73.0	72.3	75.4	74.3	−1.1
Approx. N =	(2677)	(2957)	(3085)	(3686)	(3221)	(3261)	(3610)	(3651)	(3341)	(3254)	(3265)	(3113)	(3302)	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.

[a] Answer alternatives were: (1) Don't disapprove, (2) Disapprove, and (3) Strongly disapprove. Percentages are shown for categories (2) and (3) combined.

[b] The 1975 question asked about people who are "20 or older."

TABLE 24

Trends in Annual Prevalence of Thirteen Types of Drugs Among Follow-Up Respondents 1-10 Years Beyond High School

	Percent who used in last twelve months		
	1986	1987	'86–'87 change
Approx. Wtd. N =	(6860)	(6840)	
Marijuana	36.5	34.8	–1.7s
LSD	3.0	2.8	–0.2
Cocaine	19.7	15.7	–4.0sss
"Crack"[b]	NA	3.1	NA
Heroin	0.2	0.2	0.0
Other Opiates[a]	3.1	3.0	–0.1
Stimulants, Adjusted[a,c]	10.6	8.7	–1.9sss
Sedatives[a]	3.1	2.5	–0.6s
Barbiturates[a]	2.3	2.1	–0.2
Methaqualone[a]	1.3	0.9	–0.4s
Tranquilizers[a]	5.3	5.1	–0.2
Alcohol	88.6	89.4	+0.8
Cigarettes	NA	NA	NA

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Only drug use which was not under a doctor's orders is included here.

[b] This drug was asked about in only two of the five questionnaire forms. N is two-fifths of N indicated.

[c] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

TABLE 28

Trends in Annual Prevalence of Thirteen Types of Drugs
Among College Students 1-4 Years Beyond High School

	Percent who used in last twelve months								
	1980	1981	1982	1983	1984	1985	1986	1987	'86–'87 change
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	
Marijuana	51.2	51.3	44.7	45.2	40.7	41.7	40.9	37.0	−3.9s
LSD	6.1	4.6	6.3	4.2	3.7	2.2	3.9	4.0	+0.1
Cocaine	16.9	15.9	17.2	17.2	16.4	17.3	17.1	13.7	−3.4s
"Crack"[b]	NA	NA	NA	NA	NA	NA	NA	2.0	NA
Heroin	0.4	0.2	0.1	0.0	0.1	0.2	0.1	0.2	+0.1
Other Opiates[a]	5.1	4.4	3.8	3.8	3.8	2.4	4.0	3.1	−0.9
Stimulants[a]	22.4	22.2	NA	NA	NA	NA	NA	NA	NA
Stimulants, Adjusted[a,c]	NA	NA	21.1	17.3	15.8	11.9	10.3	7.2	−3.1ss
Sedatives[a]	8.3	7.9	8.0	4.5	3.4	2.5	2.6	1.7	−0.9
Barbiturates[a]	2.9	2.8	3.2	2.2	1.9	1.3	2.1	1.2	−0.9
Methaqualone[a]	7.2	6.5	6.6	3.1	2.5	1.4	1.2	0.8	−0.4
Tranquilizers[a]	6.9	4.8	4.7	4.6	3.5	3.5	4.4	3.8	−0.6
Alcohol	90.5	92.5	92.2	91.6	90.0	92.0	91.5	90.9	−0.6
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA

NOTES: Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Only drug use which was not under a doctor's orders is included here.

[b] This drug was asked about in only two of the five questionnaire forms. N is two-fifths of N indicated.

[c] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

The CHAIRMAN. We'll now hear from Chief Levant.

Chief LEVANT. Thank you, Mr. Chairman.

I am in charge of narcotics enforcement in the City of Los Angeles, and what I'm trying to do is work myself out of a job—very seriously, work myself out of a job, because we in law enforcement in Los Angeles have discovered that interdiction and enforcement is not the answer to this Nation's drug problem; it is simply an equation of supply and demand, as has been often stated, and we whole-heartedly embrace the posture that only through a national strategy of prevention through education will we ever do anything about the epidemic of drug abuse in this country.

To that end, in Los Angeles in 1983, several years before national attention focused on the drug abuse problem, we created an educational program in cooperation with the Unified School District called DARE, which stands for "Drug Abuse Resistance Education."

DARE is an educational program which consists of a full-semester, 17-week series of lessons that is delivered by police officers of a curriculum that has been developed by professional educators in the health education field of the Unified School District in Los Angeles.

DARE is a program that goes from K through 12, and it is designed to begin teaching children four basic things prior to their involvement in narcotics. What DARE does is provide accurate information regarding alcohol and drugs to children; it teaches the students decisionmaking skills; it teaches them how to resist peer pressure—now, this is important because coming from an enforcement perspective, I have to tell you that drug pushers are not adults who are lurking around schools. Drug pushers are other children and friends and neighbors of kids who are in elementary and junior high schools. And lastly, the DARE Program gives students ideas for alternatives to drug use. This is done through positive role models involving members of the community as well as positive role models of drug-free high school seniors who come into the elementary schools and tell the children how they have maintained a drug-free, successful social life.

Since DARE started in Los Angeles, it has now spread to 38 States across the United States. It is a grassroots program; there is no Federal funding for it. It is in 25,000 classrooms as we speak, and one and one-half million children across the country are involved in the DARE Program.

The Department of Defense has adopted DARE for the DoD schools for our military personnel dependents overseas. And I am just informed that the Department of Indian Affairs is going to adopt DARE on all of the reservation schools.

One thing that has become clear to us in Los Angeles since we have become sort of the "mecca" of drug abuse in the United States is that this problem has no boundaries. Drug abuse doesn't stop at a city limit or a State line or even a national border. And what is necessary is a national policy on education prevention.

What has to be done is the Department of Education has to mandate preventive education throughout all of the schools in the United States. It doesn't do us any good to have a wonderful program in Los Angeles or in the State of Washington or in the State of Massachusetts, or in any of the other 38 States that our program is present in, without a national policy.

So I would encourage this Committee to do whatever is possible to develop and mandate a national model drug prevention educational program.

The DARE Program has been independently evaluated since its inception in 1983. We are in the third year of a seven-year longitudinal study of the children who are involved in the DARE Program as compared to those who are not in the DARE Program. In Los Angeles, the results are overwhelmingly positive in terms of not only attitudinal changes about drugs and alcohol, but also, more importantly, in behavioral changes involving drugs and alcohol.

I am happy to tell you that there have been similar results in other independent studies that have taken place in Kentucky, Hawaii and Illinois.

So the program is effective, and we believe that what we have to do is to stick with a drug-prevention education program that is a proven system such as DARE that is in place and establish it nationally before it is much too late, because I have to agree with the previous speaker—enforcement is important; interdiction is important—all of the various strategies are important in keeping the pressure on until we can create a generation that is drug-free.

It has taken us 30 years to get into this national morass of drug abuse, and it is going to take us at least 15 to get out of it.

Thank you.

The CHAIRMAN. Very good. Thank you.

[The prepared statement of Chief Levant, with an attachment, follows:]

STATEMENT OF DEPUTY CHIEF GLENN LEVANT

The critical problem of drug abuse, particularly the increasing involvement of America's youth, has rightfully captured national attention. It became clear several years ago that, despite our best efforts, the supply and use of narcotics across the Nation was not diminishing. Inasmuch as there is generally an inextricable link between supply and demand, the Los Angeles Police Department adopted a policy which had as its goal, the immediate reduction and eventual minimization of the demand for drugs.

A decision was made to concentrate efforts among young children who were still in the formative years of life and, therefore, less likely to have arrived at a conscious decision regarding drug use.

In 1983 the Los Angeles Police Department, in cooperation with the Los Angeles Unified School District, developed the Drug Abuse Resistance Education (DARE) Program to combat the introduction to, and use of, narcotics and dangerous drugs by juveniles at the elementary school level.

Under the DARE Program, police officer/instructors follow structured curriculum to teach elementary school children how to develop self esteem and to resist peer pressure so that they can say "no" to drugs. The DARE concept is gaining wide acceptance among experts in the fields of education and law enforcement in addition to being recognized as the finest program of its kind. It is imperative that DARE programs be implemented nationwide if we are to reduce the demand for drugs throughout America.

DARE is a primary prevention program aimed at children who have yet to have their first drug experience. Its goal is to reduce the incidence of drug abuse by children through presentation of a prevention curriculum by specially selected and trained uniformed police officers. The curriculum itself focuses on four major areas:

1. providing accurate information regarding alcohol and drugs;
2. teaching student decision-making skills;
3. teaching students how to resist peer pressure; and
4. giving students ideas for alternatives to drug use.

Ancillary lessons pursuant to self concept improvement, respect for the law, and personal safety are also included as part of DARE. DARE officer-instructors routinely interact with school teachers, administrators, nurses and counselors in addition to parent groups in the course of their duties.

In 1988 some 1.5 million children will have the benefit of the full DARE curriculum. The children in lower grades will be exposed to the curriculum and DARE has a parent education night at each of the schools once a semester.

In addition to its classroom work the DARE program has trained 591 law enforcement agencies and their respective school districts throughout the country. In 1987, the States of Illinois, Arizona, Virginia, Kentucky, Massachusetts, Minnesota and Washington adopted the DARE Program.

The U. S. Department of Defense has acknowledged DARE as a model drug prevention program by providing funding to have the LAPD-DARE training cadre travel to Germany to present a training seminar to Department of Defense Dependent Schools (DODDS) personnel. DODDS is the ninth largest U. S. school system and has implemented DARE in Germany, one of its five regions encompassing 20 foreign countries.

Additionally, representatives from the Northern Territory Police Department of Australia and the New Zealand Police Department have been trained to implement DARE.

The Los Angeles Police Department Drug Abuse Resistance Education (DARE) Program networks with numerous agencies across the Country. The two primary agencies in California are the State of California-Office of Criminal Justice Planning and the Los Angeles Unified School District and the primary federal agency is the Department of Justice, Bureau of Justice Assistance.

Under the provisions of the California Suppression of Drug Abuse in Schools Program (AB1983) a $478,443 grant was made available to the police departments and schools. The grant was renewable for a period of five years with a percentage increase of hard match from the City.

The Office of Criminal Justice Planning designed this Drug Suppression in Schools Program (DSP) to assist the LAPD and LAUSD in creating a drug-free environment on the school campus enabling teachers to teach and children to learn. The DSP demonstrates how the California legislature can enhance local government's effectiveness in dealing with problems related to drug abuse.

With the enactment of Assembly Bill 1983, the Governor and the Legislature directly gave support to DARE by providing funds to the City. These funds enabled the Department, working in conjunction with the Los Angeles Unified School District to increase efforts on drug prevention education. It is through this cooperation that the DARE curriculum evolved into an innovative and model drug prevention education program to be used by law enforcement agencies and school districts on a nationwide basis.

Drug education and prevention programs have existed for years, but they traditionally do not include law enforcement involvement. From DARE's beginning, the importance of law enforcement participation in drug prevention education was recognized.

With federal support through funding and nationwide promotion, it could provide an opportunity to extend DARE as a successful model prevention education program.

The Los Angeles Police Department and the Los Angeles Unified School District are cooperating in a partnership to offer Drug Abuse Resistance Education (DARE) to students enrolled in elementary and junior high schools served by the Los Angeles Police Department. The program is now operating in 403 schools from kindergarten through grade 8 in Los Angeles. Fifty-seven carefully selected and trained frontline uniformed officers are teaching students to say no to drugs, build their self-esteem, manage stress, resist pro-drug media messages, and develop other skills to keep them drug free. Additionally, high school curriculum is currently being developed to reinforce the concepts of DARE and it is anticipated to be in place by February, 1989.

School districts and police departments must work cooperatively to make drug and alcohol abuse prevention their highest priority. A commitment must be made to adopt a program such as Drug Abuse Resistance Education (DARE). DARE is an established working program, which utilizes uniformed unarmed police officers thoroughly trained in teaching techniques, elementary school operations, officer/school relationships, peer pressure resistance techniques, preparation of visual aids, communications skills, child development and classroom management skills. This training is available to any law enforcement agency who has an agreement with their concerned school district to implement the program.

The California State Attorney General's Commission on the Prevention of Drug and Alcohol Abuse recommended in 1986 that "the Education Code of the State of California be amended to require all school districts to adopt and implement K-12 drug and alcohol abuse prevention education curriculum in conformance with criteria established by the State Department of Education regarding curriculum content to ensure that all materials clearly communicate a 'No drug and alcohol use' message, are age appropriate and sensitive to the language and culture of the target audience."

The LAPD supports the Attorney General's recommendation, but feels that there is a need to take it one step further -- by adopting a nationally validated curriculum (DARE) so that a uniform message is delivered throughout the country.

Currently, methods of prevention education are fragmented. Most schools are not providing K-12 curricula on drug and alcohol abuse prevention. Leadership and guidance are needed from the Legislature to assist communities in developing and selecting programs or curricula that provide up-to-date and accurate drug information, appropriate methods for communicating the information, and the norms and values of the community.

It is recommended that DARE be considered as the model officer taught drug prevention education curriculum.

The DARE Program could be adopted by local school districts upon recommendation of the United States Department of Education (DOE). Pursuant to proposed legislation, each school district could be required to present a Drug and Alcohol Prevention Education curriculum, which meets the requirements and guidelines to be established by the DOE. To date, legislation does not call for the development of a specific all encompassing curriculum.

Successful school-based programs must not only provide students with accurate information about drugs, but must enhance self-esteem, communication skills, decision-making skills and interpersonal relationships. A successful program must also provide substance abuse education to parents. DARE provides this education and encourages parents to become involved and learn parenting techniques and help children avoid drug usage problems. DARE officers lead parenting meetings offer unique opportunities to discuss drug related issues and provide mutual support.

DARE meets both the National and California health education curriculum requirements, reaches children at the ages when they are most vulnerable to drugs and alcohol, implements pre- and post-testing that demonstrate the program's effectiveness, and incorporates the partnership of local police departments and school districts.

It is recommended that through the legislative process, the DARE Program be established as the national model drug prevention/education program, with the eventual goal being nationwide implementation of the program.

The lack of a nationwide drug prevention education program by definition is a barrier to the coordination of cost-effective services. If there were one national model drug prevention education program, such things as procurement of materials, development of curriculum, and consistency of nationwide drug prevention education would be enhanced.

There is general agreement that a comprehensive approach to prevention education involving school, law enforcement, and parents is required to successfully combat drug abuse. Available research and theory suggest that certain factors contribute to adolescent drug abuse. These include poor self-esteem, feelings of distress, family problems, low academic performance, and behavioral problems that reflect defiance.

It is recommended that Legislature select a model program which addresses these factors. Priority should be given to an existing, proven program which not only addresses these factors but has the capability to facilitate high-quality national program implementation.

The DARE Program addresses these criteria on three levels:

1. the educational level (curriculum) stresses process skills involving decision making, risk taking, self-concept improvement, and peer pressure resistance training;

2. the DARE Program provides teacher, parent and community educational programs to effectively identify and refer adolescents exhibiting drug abuse tendencies; and

3. the DARE Program drug abuse counselors at the junior high school level have implemented a prevention/intervention system for the identification and referral of students with suspected drug abuse related problems.

National-level drug priority funding should be given to the model program (DARE) which utilizes strategies that inculcate the message that substance use by youth is unacceptable. A model program that puts a substantial emphasis on helping young people develop moral understanding and a commitment to socially acceptable values, and strengthen their tendencies to behave in more socially acceptable ways.

DARE incorporates strategies for strengthening children's relationships with parents, teachers and other adults so that the no-use message communicated is meaningful. The instruction is structured to facilitate valued relationships and develop positive attitudes between our youth and adults.

It is also recommended that priority funding be given to a selected model program that is recognized by educators as being of high quality and has been proven effective.

DARE as a model program meets this criteria of being high quality educational curriculum which has been developed by LAUSD health specialist. To protect the high quality of instruction and ensure the consistency of its presentation, the LAUSD has copyrighted the curriculum. Upon receipt of proper training, the LAUSD would make the curriculum available to educators and law enforcement agencies on a nationwide basis.

As a result of the high level of acceptance by principals, teachers, the community, and students, DARE spread from 50 elementary schools in 1983 to all 345 elementary and 58 junior high schools in the City of Los Angeles. As further evidence of DARE's acceptance, 89 California communities and 591 non-California agencies, as well as, Australia, New Zealand, and the Department of Defense Dependent Schools in Germany requested and received DARE training.

It is recommended that criteria to set national-level drug program funding priority be given to law enforcement agencies and school districts who have formed a partnership. The partnership should be for the purpose of implementing a proven substance abuse program such as DARE. Far too much money is being used to proliferate new and and unproven drug prevention programs. The Legislature should give high priority to programs which have a proven success rate.

The DARE Program would ideally serve as a National model as it has proven to be effective. The Evaluation and Training Institute, an independent evaluator commissioned by the Los Angeles Police Commission, has completed a three year process evaluation of the DARE Program. They are also in the third year of a seven year longitudinal evaluation. The evaluations have shown that DARE has improved students' attitudes about themselves, increased their sense of responsibility for themselves and to police, and strengthened resistance to drugs. For example, before the DARE Program began, 51 percent of fifth grade students equated drug use with having more friends. After training, only 8 percent reported this attitude.

DARE has also changed parent attitudes through an evening program to teach parents about drugs, the symptoms of drug use, and ways to increase family communication. Before DARE, 32 percent of parents thought that it was alright for children to drink alcohol at a party as long as adults were present. After DARE, no parents reported such a view. Before DARE, 61 percent thought that there was nothing parents could do about their children's use of drugs; only 5 percent said so after the program.

In 1977 and every two years since, the National Gallup Youth Survey has asked youngsters ages 13 through 17 to name the biggest problem facing people their age. Each year drug abuse has been the number one response. Just last spring, the WEEKLY READER published the results of a survey of 500,000 children in grades 4 through 12, who were asked what the one thing they thought is most important for schools to do to fight drugs. Their overwhelming response was "Teach Us The Facts".

Most drug abuse programs that have been used focus on three main messages: responsible use, it's your decision, and do drugs but set limits on usage. Obviously these concepts have not discouraged drug use and in effect tell youngsters that it's their decision whether or not to break the law.

In general, existing research suggests that increases in knowledge are relatively easy to obtain, changes in attitude are more difficult, and changes in behavior, particularly lasting changes, are rare.

Historically, prevention programs have focused on a single level of influence and have directed their emphasis to one or more factors within that level. The influences that increase or decrease the probability that young people will use substances are found at all levels of society; including the individual, the peer group, the family, the school, the community and the larger society.

Programs that focus on the individual include those to increase knowledge, to change beliefs, and to meet social or psychological needs. There are programs based on the theory that youth use drugs because they are under pressure from their peers. Programs are available that aim at improving family relationships and parenthood skills, increasing parents' awareness of their role in shaping children's attitudes or increasing parents' control over their children. There are programs to develop and enforce school policies for handling drug-related problems, and to limit the availability of drugs on campus. Additionally, there are mass media campaigns to provide a consistent no-use message.

Available evaluation research of the single-strategy programs suggests weak, inconsistent, and short-term effects, or, more commonly no effect at all.

With the signing of the Omnibus Anti-Drug Abuse Act in 1987, the Department of Education will be able to help the states rid their schools of drugs by providing a comprehensive list of accurate, up-to-date books, films, and other materials with a "no-use" message. The Department of Education's Drug Abuse Policy Oversight Staff will develop criteria for an effective drug abuse prevention curricula by September, 1988.

All the research and development work for an effective model program for drug use prevention education has been done. It is embodied in the DARE Program.

Nationally, DARE has been recognized as a comprehensive educational program featuring a formal kindergarten through eighth grade curriculum. It is the most comprehensive and effective drug prevention education program in the country. In addition to being implemented in progressive communities throughout California, DARE is also being replicated on a national level. It has received the enthusiastic oral and written endorsements of students, parents, and the business community.

Several states mandate that drug education "shall be offered" but leave the choice of when to offer it and what topics or skills to address to the discretion of local school districts. The "Drug-Free Schools and Communities Act of 1986", which provides funds for school-based prevention efforts, has given additional impetus to the search for viable and effective curricula.

DARE incorporates strategies for strengthening children's relationships with parents, teachers and other adults so that the no-use message communicated is meaningful. The instruction is structured to facilitate valued relationships and develop positive attitudes between our youth and adults.

In order to respond to the national and international demand for the DARE Program, DARE AMERICA was created.

Headquartered in Los Angeles, DARE AMERICA will support implementation of DARE training and curriculum and coordinate fund-raising and sponsorship opportunities on the national level. It will also regularly monitor instruction standards and program results. Nationally prominent business and community leaders, such as Nathan Shapell, who will serve as president of DARE AMERICA, and philanthropist Dr. Armand Hammer will administer DARE AMERICA's goals.

The formation of DARE AMERICA is the first step toward making the DARE Program a part of every school's curriculum nationwide. It will provide financial support for officer training, student materials and teaching aids for communities wishing to implement the DARE Program.

A three day in-service training seminar has been scheduled in Los Angeles for all previously trained DARE instructors. This seminar will provide information and instruction which will introduce officers to the concepts and operation of Regional Training Centers in accordance with the established criteria. The seminarwill provide a forum for DARE officers to network and discuss areas of mutual concern. The seminar will feature 24 workshops covering a wide range of DARE related topics including program implementation, management and specialized training.

The adoption of a nationwide model program would enhance the local school district's ability to provided quality instruction to students. It would also give the country a consistent uniform broad based prevention education system. It is further recommended that such a model program be based on criteria established by the DOE which includes:

a. evidence of measurable outcomes of program effectiveness such as reduction in student drug use or reduction in student suspensions or expulsions as a result of decreased drug abuse;

b. demonstration of school policies and consistent enforcement, including clear and specific rules about constitutes a drug offense, policies for monitoring drug use, establish procedures and consequences for violation of school policies, and security measures, if needed, to eliminate drug use in school;

c. evidence of a comprehensive drug prevention curriculum that teaches drug use is wrong; this curriculum should provide information about the symptoms and harmful effects of drug use, especially the three substances characterized as gateway drugs-marijuana, alcohol, and tobacco; it also should teach how to resist peer pressure to use drugs and promote life skills, including interpersonal communication, assertiveness, and problem solving;

d. promotion of healthy activities as an alternative to drug use;

e. demonstration of community support and assistance, including the assistance of local law enforcement agencies in planning, implementing, and assessing drug prevention activities; and,

f. documented involvement of parents.

As Mr. William Bennett, United States Secretary of Education stated:

> "The foremost responsibility of society is to nurture and protect its children. In America today, the most serious threat to the health and well being of our children is drug abuse...We must work to see that drug use is not tolerated in our homes, in our schools, or in our communities. Because of drugs, children are failing, suffering, and dying. We have to get tough, and we have to do it now."

This poignant commentary echoes the sentiments of parents, educators and law enforcement professionals in conveying the urgency of the drug abuse problem. All of the young people of the nation need protection, and the best protection they can have is the ability to defend themselves against the false promise of drugs. The DARE Program is the most comprehensive officer/instructor drug prevention education program in the country and it will help provide this much needed protection.

LOS ANGELES POLICE DEPARTMENT

DARYL F. GATES
Chief of Police

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July 1, 1988

The Honorable Edward M. Kennedy
United States Senate
Chairman, Committee on Labor and
 Human Resources
Washington, D. C. 20510-6300

Dear Senator Kennedy:

Thank you for expressing interest in the Drug Abuse Resistance Education (DARE) Program. We are very proud of this program and are happy to share this information with all interested parties.

The DARE Program began in Los Angeles during 1983 when it became apparent that stopping the supply of illegal drugs was an impossible task. Children were becoming involved in drug use at earlier ages and in greater numbers than ever before. In order to educate elementary school age children to the consequences of drug abuse and to assist them in developing skills to resist becoming involved in drug use, the Los Angeles Police Department and the Los Angeles Unified School District combined forces to develop a drug abuse prevention program.

DARE is a program designed to address the drug problem by significantly reducing the demand for and abuse of drugs and alcohol. It has not been a problem to generate interest in the DARE Program among other law enforcement agencies. Information on the DARE Program has been disseminated through presentations to local and national law enforcement associations and articles in several law enforcement publications including the National Institute of Justice Reports.

Since its inception, DARE has served as a model program for agencies throughout the country. In order to assist other communities in implementing programs to meet their needs, the Los Angeles Police Department has developed training classes for other agencies. Interest in this training has been widespread. Over 591 agencies from 37 states as well as the Department of Defense and New Zealand and Australia have already been trained in the DARE Program. Arizona, Illinois and Virginia have adopted DARE as the model drug education program for their states.

AN EQUAL EMPLOYMENT OPPORTUNITY—AFFIRMATIVE ACTION EMPLOYER

If a bias against diverting manpower and resources to education programs exists within law enforcement, it is due to very real budgetary limitations rather than philosophical reservations regarding the use of law enforcement resources in prevention and education programs.

In 1986, the Bureau of Justice Assistance (BJA) awarded the Los Angeles Police Department a grant of $140,000 to share its unique DARE Program with other communities throughout the United States. With the financial support of BJA, the DARE Program was replicated in designated communities located in various geographic areas across the country.

Annual budgets for the DARE Program will vary widely throughout the country. The estimated costs range from approximately $2.50 per student to $12.50 per student, depending on the number of students, the number of DARE instructors, officer salaries and the extent to which student materials are supplied as incentives.

Traditionally, funding for the DARE Program has come from a variety of sources. In addition to public funds, the private sector and the business community have significantly contributed to meeting the costs of the DARE Program.

Without the partnership of law enforcement, educators and the community, DARE would not have achieved the level of success it has enjoyed since its beginning.

If we can be of any further assistance, please feel free to contact Deputy Chief Glenn Levant, Commanding Officer, Bureau of Special Investigation, directly at (213) 485-3277.

Very truly yours,

DARYL F. GATES
Chief of Police

The **Chairman**. Ms. Bozich.

Ms. **Bozich**. Thank you, Mr. Chairman.

It is a privilege to testify before you today and to share with you some evidence that substance abuse prevention efforts are having an impact in Utah and are making a difference in the lives of our children and youth.

We believe our success is due to multiple factors. The key to future success, however, will be found in the strong foundation of education and prevention programs which have been established in Utah in recent years.

In Utah, our systematic efforts to address prevention began in 1983, when the State legislature appropriated funding which launched a Statewide initiative to establish school- and community-based prevention programs. Over the last five years, a Statewide network of substance abuse prevention specialists has been established, and a variety of prevention programs targeted at youth, parents and whole communities have been implemented.

The most extensive of Utah's prevention efforts and one that is having a measurable impact is our K-12 Alcohol, Drug and Tobacco Prevention Program, which consists of a multicomponent drug education curriculum and teacher in-service training. Since 1983, the program has been implemented in all of Utah's 40 school districts and over 8,000 educators have been trained.

The focus of the curriculum is on the development of students' personal and social competencies, including problem-solving, decisionmaking, communication, coping, valuing and resistance to persuasion skills, accompanied by knowledge about drugs and healthy alternatives to drug use.

The K-12 program is being evaluated longitudinally. Data collected on eighth grade students who have received two years of instruction in the curriculum indicate that overall it is effective in slowing the rate of initiation of substance use, decreasing the use of some substances, and preventing an increase in intentions to use substances in the future.

The K-12 program is also effective in positively impacting some of the attitudes, values and social skills which influence a young person's decision to use or not use drugs.

The model on which the curriculum is based also appears to be valid.

For many variables, the preventive impact of the curriculum is cumulative, becoming stronger with each additional year of exposure. In addition, the earlier the exposure, the greater the impact.

The most recent data, for the 1986 to 1987 school year, show the curriculum had both significant outcome and impact effects for eighth grade students who were exposed to the program for two years, in both the seventh and eighth grades, when compared to students who received it for only one of the two years or not at all.

Student outcome effects are defined as the effects of the curriculum on student attitude, personality and skill variables, which are deemed crucial to preventing future substance abuse.

Student impact effects are the target variables for prevention, including actual rates of substance use, initiation of use, and intentions to use substances in the future.

The 1986 to 1987 data also indicated that the K-12 curriculum delayed the onset of substance use for a substantial number of Utah's junior high school students. For example, when the students who received the curriculum for two years were compared to students who had no exposure, the following was found: In the unexposed group, there was a 15 percent increase in alcohol use, compared to only a 6 percent increase in the curriculum group. There was an 8 percent increase in tobacco use in the unexposed group, compared to only a 2 percent increase in the curriculum group; and a 7 percent increase in marijuana use in the unexposed group compared to only 2 percent, again, in the curriculum group.

Translated into real numbers, this means that of the total eighth grade student population in Utah, it is estimated that the K-12 curriculum prevented or delayed 2,550 students from initiating alcohol use, 1,950 from initiating tobacco use, and 1,490 from initiating marijuana use.

With the passage of the Omnibus Anti-Drug Abuse Act of 1986, our Nation's schools and communities have become the recipients of substantial new resources for drug education and prevention.

At the same time, the challenges have never been greater, and the focus is very much on the schools as the primary vehicles for reaching youth. The challenges include the need to develop prevention programs for the general population as well as high-risk youth; to maximize impact with limited funding; and to document program effectiveness.

To meet these and other challenges, the following elements will be essential. First, we must recognize that the long-term answer to the problem is prevention. Prevention is a pro-active process. Reactive, after-the-fact strategies such as law enforcement and treatment are essential, but alone cannot solve the problem.

Prevention is not only the most promising and positive approach, but also the most cost-effective.

Secondly, we must make a commitment to strengthening program implementation and long-term funding. Prevention programs do not typically yield immediate results, but require time to stabilize before their impact is evident.

The aims of prevention programs, to deter initiation of drug use and reduce drug use, require continuing effort. We must give prevention time to work.

Third, we need funding and models for a comprehensive school-based continuum of services, including training for administrators and teachers, and programs targeted at high risk youth. Schools must be empowered to expand their continuum to include targeted prevention, early intervention, identification, assessment and referral, and post-treatment support programs. Models for effective programs for high-risk youth are needed, and should be disseminated to State and local education agencies. Training for educators in the identification of youth at risk and in intervention procedures will be essential.

Fourth, demonstration evaluation projects must be conducted to determine the most effective prevention strategies and the most effective components of comprehensive programs.

We must continue to identify and test those strategies which show the most promise. Evaluation must be a high priority to ensure that limited dollars are utilized in the most effective way.

The time frame for evaluation projects must also be sufficient to enable programs to show impact.

Finally, multi-agency cooperation and coordination of efforts is essential to maximize resources, prevent duplication of services, and to convey a consistent message regarding drug use.

In conclusion, over the past five years, Utah has put considerable resources into the prevention of alcohol and drug abuse among our youth, and these efforts have made a difference. The successes are due to the combined efforts of grassroots organizations, civic groups, State and local substance abuse education, law enforcement, and health agencies, leadership from our Governor's Office, and Utah's First Lady, and many others.

We are grateful for the Federal initiatives and resources you have provided and welcome you as our partners in this effort. With your continued support, and with prevention as the foundation of our efforts, I am optimistic that we will reach our shared goal of a healthy, drug-free future for our children and youth.

Thank you, Mr. Chairman, for the opportunity to testify.

[The prepared statement of Ms. Bozich with an attachment and responses to questions submitted to her follow:]

TESTIMONY OF

MARY LOU BOZICH, EDUCATIONAL SPECIALIST
SUBSTANCE ABUSE PREVENTION EDUCATION
UTAH STATE OFFICE OF EDUCATION

BEFORE THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

JUNE 16, 1988

WASHINGTON, D.C.

Mr. Chairman and Members of the Committee:

I am Mary Lou Bozich, Educational Specialist for Substance Abuse Prevention Education Programs at the Utah State Office of Education. The Utah State Board of Education is charged by Utah Law with the responsibility for adopting rules to provide for instruction about alcohol, tobacco, and controlled substances for students at each grade level. The State Office of Education administers and provides curriculum materials for a K-12 Alcohol, Drug, and Tobacco Prevention Education Program, which is the product of a multiagency partnership with the Utah State Division of Substance Abuse and the Utah Department of Health. The State Office of Education also administers the education portion of the new federal funds awarded under the Drug-Free Schools and Communities Act (P.L. 99-570: Omnibus Anti-Drug Abuse Act of 1986).

It is a privilege to testify before you today and to share with you some evidence that substance abuse prevention efforts are having an impact in Utah and are making a difference in the lives of our children and youth. We believe that our success is due to multiple factors. The key to this and future success, however, is to be found in the strong foundation of education and prevention programs established in Utah in recent years.

In 1982-83 the State Division of Substance Abuse conducted an Incidence and Prevalence Survey which indicated a substantial number of 12-17 year olds were either using substances regularly or experiencing significant problems as a result of their drug use. Twenty percent of 12-17 year olds were found to be regularly using alcohol; 19 percent were regularly using medical drugs for non-medical reasons; 13 percent were regularly using tobacco; and seven percent were regularly using street drugs, primarily marijuana and cocaine. In addition, it was estimated that nearly 13,000 12-17 year olds were experiencing severe or extreme problems as a result of their drug use and were in need of treatment.

While the need for intervention and treatment programs was and still is great, we recognize that the long-term answer to the problem is one of preventing substance abuse before it begins. In Utah, our systematic efforts to address prevention began in 1983 when the State Legislature appropriated funding which launched a statewide initiative to establish school and community-based prevention programs. Over the past five years, a statewide network of substance abuse prevention specialists has been established and a variety of prevention programs targeted at youth, parents, and whole communities, have been implemented throughout Utah.

The most extensive of Utah's prevention efforts, and one that is having a measurable impact on the problem, is the K-12 Alcohol, Drug, and Tobacco Prevention Education Program, which consists of a multicomponent drug education curriculum and teacher inservice training. Since 1983, the curriculum has been implemented in all 40 of Utah's school districts and over 8,000 educators have been trained.

From a historical perspective, it is not surprising that many might question the efficacy of education in impacting the drug problem among youth. In the past we made numerous attempts with relatively little success. Throughout the 1960's and early 1970's, the favored approach was a strictly informational one, often characterized by scare tactics, and typically presented in one-shot doses. These strategies lacked a corresponding opportunity for youth to acquire the skills they needed to use the information in healthy, responsible ways. The result was the creation of perhaps the most educated generation of drug users and abusers out nation has known, characterized by increased alcohol and drug use, and a corresponding loss of credibility among educators.

By the mid-1970's our approach to drug education was reconceptualized as we shifted our focus from the drugs themselves to the people who were using them. The new approach involved affective education strategies focusing on building self-esteem and healthy life skills such as problem solving, decision making, communication, coping, and valuing. While the affective approach may have improved decision-making skills, it often eliminated the information about drugs essential to making an informed decision, and was also ineffective as a prevention strategy.

The current approach to prevention education, and the theoretical basis for Utah's K-12 program, recognizes that prevention programs are most likely to succeed if they combine personal and social growth with drug information. In addition to developing knowledge, and personal and social competencies, a sound program must also provide healthy alternatives to drug use and reach into families and the community for support of the concepts being taught and to impact social policy.

The K-12 program is being evaluated longitudinally. Data collected on eighth grade students who have received two years of exposure to the curriculum indicate that it is effective in slowing the rate of initiation of substance use, decreasing the use of some substances, and preventing an increase in intentions to use substances in the future. The K-12 program is also effective in positively impacting some of the attitudes, values, and social skills which influence a young person's decision to use or not use drugs. The model on which the curriculum is based also appears to be valid (Attachment A). For many variables, the preventive impact of the curriculum is cumulative, becoming stronger with each additional year of exposure. In addition, the earlier the exposure, the greater the impact.

The most recent data, for the 1986-87 school year, show the curriculum had the following significant effects for eighth grade students who were exposed to the program for two years, in both the seventh and eighth grades, when compared to students who received it for only one year or not at all.

Student Outcomes:

-- further increased knowledge of the effects of alcohol, tobacco, and marijuana over previous year;

-- further slowed the decline in resistance to peer pressure; and

-- further slowed the increase in rates of "rebellious" behavior.

Additional significant changes not shown in the previous year's results are:

-- increased reports of social participation; and

-- strengthened intentions to not use substances in the future.

Student Impacts:

In addition to changes in substance use behavior shown in the previous year's data, exposure to the K-12 curriculum:

-- further slowed the initiation of alcohol use;

-- slowed the rate of initiation of smokeless tobacco use;

-- decreased current monthly rate of use of smokeless tobacco;

-- decreased current monthly rate of use of cocaine;

-- further slowed a rise in intentions to use alcohol;

-- prevented a rise in intentions to use smokeless tobacco;

-- prevented a rise in intentions to use cocaine; and

-- prevented a rise in intentions to use other drugs.

The 1986-87 data also indicated that the K-12 curriculum delayed the onset of substance use for a substantial percentage of junior high school students. It is estimated that two years of exposure to the curriculum prevented or delayed the initiation of alcohol use by 2,550 students, and prevented or delayed 1,950 cases of tobacco initiation and 1,490 cases of marijuana initiation.

The literature on prevention education suggests that the success of Utah's K-12 program is most likely due to the following characteristics, many of which are cited as recommendations for effective programs in the Report to Congress and the White House on the Nature and Effectiveness of Federal, State, and Local Drug Prevention/Education Programs (October, 1987):

1. The program utilizes a multicomponent approach which combines the development of personal and social competencies with drug

information, is based on the etiology of youth drug abuse and sound prevention principles, and has well defined goals.

2. The program includes an intensive three-day teacher inservice — training component.

   Evaluations of ineffective drug education programs have shown that some do not receive adequate implementation, a factor attributed largely to insufficient teacher training.

3. Utah's schools and local substance abuse agencies have made a commitment to a long-term implementation effort, including funding resources.

   The first year of exposure to Utah's K-12 program did not yield a reduction in substance use among students. If we had become discouraged and terminated the program, Utah's youth would not have the benefits the program is now yielding after continuous implementation. Short-term approaches have not proven to be effective prevention strategies.

4. The K-12 curriculum is part of a comprehensive school-based prevention effort which includes policy, peer programs, and parent and community involvement.

Research suggests that drug education curriculum is not effective in a vacuum. Programs which involve collaboration with other agencies and systems both maximize their resources and send a more consistent message regarding substance use/abuse. While schools provide the ideal setting for prevention education programs, they did not create the problem nor should they be expected to solve it alone.

5. The K-12 prevention education program has been integrated into the Utah State Board of Education's Core Curriculum in Healthy Lifestyles as a key component of the health education requirements.

   A basic premise of prevention programs is that they are most likely to be successful when they are integrated into the ongoing activities of schools and are not simply additions to the setting.

6. The K-12 program is undergoing a longitudinal evaluation for the purpose of assessing overall impact and effective components and identifying weaknesses which may be targeted for improvement.

   Curriculum enhancement and update activities are guided by the evaluation findings. For example, ability to resist peer persuasion has been identified as a key component, but one that is relatively weak in the curriculum. In response to this finding, additional activities which teach refusal skills will be incorporated into the curriculum at appropriate grade levels.

Although we have made considerable progress in Utah, particularly in the area of primary prevention, we have a great deal more to do to effectively address the needs of youth at risk for substance abuse. One of the indicators that our primary prevention education efforts are successful has been the increased identification of youth at risk. Due to limited resources, however, prior to the Drug-Free Schools and Communities funds, we were not addressing high risk youth in a systematic way. A few model programs existed, but we lacked sufficient resources for implementing them statewide. The new federal funds are enabling Utah's schools not only to enhance and expand current primary prevention efforts for the general student population, such as the K-12 curriculum, but to begin to expand their continuum of prevention programs to meet the needs of high risk youth as well.

The Utah State Board of Substance Abuse has established a Continuum of Services which identifies four types of programs, three of which are prevention oriented (Attachment B). Included are primary prevention programs for the non-using, general population; targeted prevention programs for populations at risk of substance abuse; and early intervention programs for individuals characterized by experimental or problematic use of substances. All are within the definition of education and prevention as specified by the Drug-Free Schools and Communities Act. It is our goal in Utah that each school/school district establish a full continuum of education and prevention services.

With the passage of the Omnibus Anti-Drug Abuse Act of 1986, our nation's schools and communities have become the recipients of substantial new resources for drug abuse education and prevention. At the same time, the challenges have never been greater and the focus is very much on the schools as the primary vehicles for reaching youth. The challenges include the need to develop prevention programs for the general population as well as high risk youth, to maximize impact with limited funding, and to document program effectiveness. To meet these and other challenges, the following elements will be essential:

1. Recognition that the long-term answer to the problem is prevention. Prevention is a proactive process designed to keep a problem from occuring in the first place. Reactive, after-the-fact strategies such as law enforcement and treatment are essential, but alone cannot solve the problem. Prevention is not only the most promising and positive approach, but also the most cost-effective.

   Proactive prevention programs aimed at strengthening individuals may also provide substantial payoffs in terms of strengthening families, schools, and communities. Reactive strategies result in considerable costs not only in terms of unemployment, morbidity and mortality, treatment, welfare, crime, incarceration, and accidents, but also in terms of loss of individual potential, health, school and job performance, families, and relationships. In 1983, the combined costs of alcohol and other drug abuse in

Utah exceeded $522 million, or more than $328 per individual Utahn. In fiscal year 1985, the treatment budget alone was $10,700,618, or approximately $6.42 per Utahn. During the same year, the cost of comprehensive prevention programming throughout the state was $2,564,897, or only $1.53 per Utahn.

Despite significant law enforcement efforts, this approach is barely making a dent in the problem. In a June, 1987 report to the Utah State Board of Education, United States Attorney for Utah, Brent D. Ward, addressed the impact of law enforcement efforts. Since 1983, the Utah U.S. Attorney's Office has successfully prosecuted a number of major drug cases. In assessing the progress, however, Mr. Ward reported the following: "It is a sad truth that a steady stream of convictions, prison sentences, and property seizures has had little perceptible impact upon the drug problem in Utah. I have never before had the conviction that any crime problem was outstripping the capacity of law enforcement to respond. I now have such a conviction." In response to this, a "United States Attorney's Drug Prevention Program for Utah High Schools" was launched in the 1986-87 school year and continued through the 1987-88 year. Nearly all of Utah's high schools and some middle/junior high schools have benefitted from the program, which combines information about the harmful effects and legal consequences of drug use with emphasis upon positive role models, self-esteem, self-control, and personal responsibility in decision making. Although an "unprecedented step" for the U.S. Attorney's Office to take, Mr. Ward believes it has been worthwhile and has stated that it is "every bit as important as any drug case [the U.S. Attorney's Office] has prosecuted."

The success of treatment programs is at best minimal, with a very high probability of relapse within the first year following completion of a treatment program. One youth treatment provider in Utah estimated that even the most comprehensive programs, including total family involvement and long-term aftercare, would not be able to claim a success rate of greater than 40 percent, and, more realistically the average success rate is much lower.

2. A commitment to strengthening program implementation and long-term funding.

Prevention programs do no typically yield immediate results but require time to stabilize before their impact is evident. The aims of prevention programs -- to deter initiation of drug use and reduce drug use -- require continuing effort. The essential skill development that is part of an effective prevention program requires ongoing teaching and reinforcement. We must give prevention time to work.

The amendments to the Drug-Free Schools and Communities Act of 1986, as contained in the authorizations of appropriations of H.R. 5 (P.L. 100-297, passed April 28, 1988) and as proposed in

S. 2205, the "Omnibus Anti-Drug Abuse Act of 1988, will help to ensure long-term program efforts.

3. Funding and models for a comprehensive school-based continuum of services, including training for administrators and teachers and programs targeted at high risk youth.

The Report to Congress states that while virtually all local education agencies offer instruction in drug education and prevention, a majority do not offer services to high risk youth and only about half of the state education agencies provide technical assistance to LEAs to improve services to high risk youth. Schools must be empowered to expand their continuum to include targeted prevention, early intervention, identification/assessment/referral, and post-treatment support programs. Models for effective programs for high risk youth are needed and should be disseminated to state and local education agencies. Training for educators in the identification of youth at risk and in intervention procedures will be essential.

4. Demonstration evaluation projects to determine the most effective prevention strategies and the most effective components of comprehensive programs.

To date, evaluations of the various drug education strategies have been insufficient or inconclusive. We have made considerable progress since the early ineffective and often counterproductive informational and scare tactic approaches, but we still have much to learn about what works in prevention. We must continue to identify and test those strategies which show the most promise. Evaluation must be a high priority to ensure that limited dollars are utilized in the most effective way. The timeframe for evaluation projects must also be sufficient to enable programs to show impact.

The Utah State Office of Education and the University of Utah are currently involved in a demonstration evaluation project funded by the U.S. Department of Education to implement a "Comprehensive High School Substance Abuse Prevention Effectiveness Project." The effectiveness of various levels of prevention programming will be tested through projects planned and implemented by school teams. Projects will target both the general student population and high risk youth. The importance of school climate and bonding to the school will also be examined. While it is likely that students will benefit from the projects and some valuable information will emerge from the study, in reality, the 18-month period of the grant is not sufficient to truly measure the effectiveness of the model.

5. Multiagency cooperation and coordination of efforts.

A basic premise of effective prevention programs is that they are most likely to succeed if they involve active cooperation and the combined efforts of schools, families, and communities. All aspects of the community must be involved including education, law enforcement, treatment agencies, parents, medical professionals, and others. Coordination of efforts is essential to maximize resources, prevent duplication of services, and convey a consistent message regarding drug use.

While interagency coordination is critical, leadership must be a shared role to the degree that ensures the ongoing contribution of each area of expertise. Educators, in cooperation with prevention professionals in supporting agencies, are the most appropriate persons to make decisions regarding school programs; law enforcement officials must make decisions relevant to their domain; and treatment professionals must make treatment-related decisions. If programs are to become integrated into the ongoing activities of agencies, they must generate ownership.

The concept of a "Drug Czar", representing a single area such as law enforcement as proposed in S. 2205, presents potential setbacks to progress. One possible outcome might be the favoring of law enforcement and other supply reduction efforts over prevention and other demand reduction strategies. The current Omnibus Act already places considerably greater emphasis on supply reduction than on demand reduction. One estimate is that approximately 200 times more money is currently spent on reducing the supply of drugs entering the country and on law enforcement than on reducing the demand. Even with the limited documentation of prevention program effectiveness, many would agree that focus on demand reduction is an inherently more positive approach and more effective than supply reduction techniques.

Another possible consequence of the "Drug Czar" concept is increased bureaucracy which would impede the flow of funds to their destinations in schools and communities. Finally, there would be the potential for dictating to schools and communities regarding programming efforts, thus countering the philosophy of the Drug-Free Schools and Communities Act of 1986, which emphasizes the importance of decision making at the local level. The federal initiative in the war against drugs has been significant and the President, the First lady, and the Congress have provided needed national leadership. If we are to win the war, however, individual states, communities, agencies, and people must own the problem. To recall an old adage, people own and support what they help create. While coordination is essential, we must continue to emphasize its importance at the local level.

In conclusion, over the past five years, Utah has put considerable resources into the prevention of alcohol and drug abuse among our youth and these efforts have made a difference. Trend data gathered by the Utah State Division of Substance Abuse in 1987 show significant declines from 1982 in the 18-25 year old population in the percent ever using marijuana, hallucinogens, cocaine, amphetamines, tranquilizers, and analgesics. Significant declines were also noted in the percent regularly using alcohol, marijuana, and amphetamines. Downward trends in the regular use of cocaine, although not statistically significant, were also noted (Attachment C). It is our belief that prevention efforts have contributed significantly to these findings including, but not limited to, implementation of education and awareness programs, media campaigns, school and community-based prevention programs, and the passage of legislation to stiffen penalties for violating laws and to increase and enable the identification of high risk youth. The successes are due to the combined efforts of grass roots organizations; civic groups; state and local substance abuse, education, and health agencies; leadership from the Governor's Office and Utah's First Lady; and many others.

We are grateful for the federal initiatives and resources you have provided, and welcome you as our partners in this effort. With your continued support, I am optimistic that we will reach our shared goal of a healthy, drug free future for our children and youth.

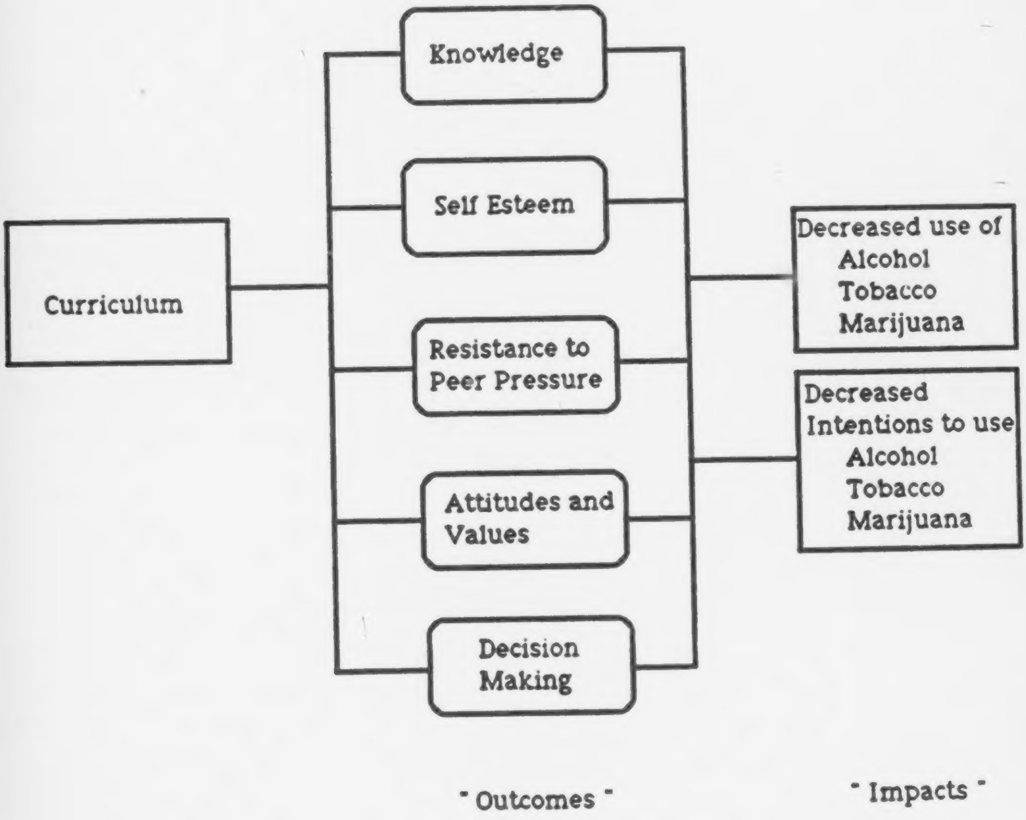
Thank you, Mr. Chairman, for the opportunity to testify at this hearing. I would be pleased to answer any questions that you and the members of the Committee might have.

Attachment A

UTAH ALCOHOL, DRUG, AND TOBACCO PREVENTION EDUCATION PROGRAM

Curriculum Impact Evaluation*

Model of Curriculum Impact and Outcome Effects


Curriculum
Knowledge
Self Esteem
Resistance to Peer Pressure
Attitudes and Values
Decision Making
Decreased use of Alcohol Tobacco Marijuana
Decreased Intentions to use Alcohol Tobacco Marijuana
" Outcomes "
" Impacts "

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* The curriculum impact evaluation is currently being conducted by the University of Utah, through a contract with the Utah State Division of Substance Abuse.

Attachment B

UTAH STATE BOARD OF SUBSTANCE ABUSE

CONTINUUM OF SERVICES

DEFINITION OF PREVENTION

Prevention is a proactive process which focuses on capacity-building for individuals, families, institutions, and organizations--including specifically identified high-risk individuals and/or groups within the population.

PROCESS - PREVENTION

This process is designed to promote the personal and social well-being of the individual to act on behalf of self and others in ways that promote positive lifestyles. Such actions thereby reduce or inhibit the abuse and/or illegal use of alcohol and other drugs and associated physical, emotional, or social impairment.

DEFINITION OF TREATMENT

Treatment is an intervention process for the purpose of assisting dysfunctional individuals or families to achieve a functional lifestyle free from alcohol and drug abuse.

PROCESS - TREATMENT

A full range of services and support systems are used to make the transition from dysfunctional to functional living. Sensitivity to specific individual and family needs is emphasized, as well as treatment in the least restrictive appropriate setting.

The single criteria used to distinguish points on the continuum is the intent of the service provider to differentiate a target population in terms of risk or usage factors. Specific service strategies were not used as criteria because many of them can legitimately fit under more than one continuum point.

Primary Prevention	Targeted Prevention	Early Intervention	Treatment
Services designed to preclude the onset of alcohol- and drug-related problems through skill-building and educational measures which promote attitudes and behaviors that are incompatible with substance abuse. Such services may be applied within specific groups or across the general population.	Services which target vulnerable high-risk groups within the population who are characterized by identifiable factors and for whom skill-building and educational measures can be undertaken to reduce the likelihood that problematic use of alcohol and other drugs will develop.	Services which target individuals or groups who are characterized by experimental or problematic use of alcohol and other drugs and for whom skill-building and educational measures can be undertaken to alleviate such behaviors and reduce the likelihood that patterned abuse or dependence will develop.	Services which target individuals and/or families who are functionally impaired--physically, psychologically, or socially--in association with the patterned abuse of or dependence on alcohol and other drugs.
Services including, but not limited to, the following must be addressed to meet this requirement.	Services including, but not limited to, the following must be addressed to meet this requirement.	Services including, but not limited to, the following must be addressed to meet this requirement.	Services including, but not limited to, the following must be addressed to meet this requirement.
o School-Based Education/ Prevention Programs o Community-Based Education/ Prevention Programs o General Population Awareness and Information	o School-Based Education/ Prevention Programs o Community-Based Education/ Prevention Programs o Specific Population Awareness and Information	o First Offender Programs o Diversionary Programs	o Assessment/Evaluation/Referral o Short-Term Crisis (24-hour accessibility) o Long-Term Support o Medical Need

Attachment C

UTAH STATE DIVISION OF SUBSTANCE ABUSE

TRENDS IN UTAH DATA IN 1987

Ages 18-25 Years

A. Significant declines from 1982 in the percent EVER USING marijuana, hallucinogens, cocaine, amphetamines, tranquilizers and analgesics are observed.

B. Significant declines in the percent REGULARLY USING alcohol, marijuana and amphetamines are seen. Downward trends in the regular use of cocaine and analgesics are also noted, however, these differences are not statistically significant.

C. The percent who indicated they had driven at or above the .08 B.A.C. level (intoxicated level produced by four or more drinks in one hour) during the prior 30 days, declined from 14.8% in 1982 to 6.2% in 1987.

Ages 26 & above

A. A substantial decline in the percent EVER USING analgesics is noted. No significant increases or decreases in the percent EVER USING other substances is observed.

B. No significant increases or decreases in the percent of REGULAR USERS of any of the substances is seen.

C. The percent who indicated they had driven at or above the .08 B.A.C. level during the prior 30 days declined for 26-35 year olds from 8.9% in 1982 to 4.2% in 1987; and for 36-59 year olds from 3.5% in 1982 to .9% in 1987.

N of cases for surveys for Utah are: Ages 18-25, 476 in 1987, 964 in 1982; Ages 26 & above, 573 in 1987, 3,400 in 1982.

TRENDS IN ALCOHOL & DRUG USE IN UTAH & THE NATION
FROM 1979 to 1987

	AGES 18 - 25 YEARS												AGES 26 & ABOVE											
	% Ever Using in Lifetime						% Regular Users						% Ever Using in Lifetime						% Regular Users					
SUBSTANCE/ DRUG TYPE	Utah 1987	Utah 1982	Utah 1979	Nation 1985	Nation 1982	Nation 1979	Utah 1987	Utah 1982	Utah 1979	Nation 1985	Nation 1982	Nation 1979	Utah 1987	Utah 1982	Utah 1979	Nation 1985	Nation 1982	Nation 1979	Utah 1987	Utah 1982	Utah 1979	Nation 1985	Nation 1982	Nation 1979
Alcohol (Beer, Wine Spirits)	66.1	68.7	66.2	92.8	94.6	95.3	36.8	43.4	38.5	71.5	67.9	75.9	64.9	63.5	63.5	89.3	88.2	91.5	29.7	31.6	27.9	60.7	56.7	61.3
Marijuana	31.2	47.3	39.6	60.5	64.1	68.2	3.7	15.7	21.0	21.9	27.4	35.4	19.9	17.6	12.3	27.2	23.0	19.6	1.3	3.3	3.9	6.2	6.5	6.0
Hallucinogens	9.9	16.5	13.0	11.5	21.1	25.1	.4	1.3	3.3	1.6	1.7	4.4	5.2	4.6	3.3	6.2	6.4	4.5	0.0	.2	.3	**	**	**
Cocaine	13.0	18.1	14.8	25.2	28.3	27.5	.4	4.6	5.0	7.7	6.8	9.3	6.6	5.4	4.1	9.5	8. 5	4.3	.12	.7	.7	2.1	1.2	0.9
Heroin	1.2	0.9	2.6	1.2	1.2	3.5	.4	.04	.6	**	**	**	.5	1.2	1.4	1.1	1.1	1.0	0.0	0.0	.1	**	**	**
Amphetamines*	6.2	21.4	NA	17.3	18.0	18.2	.4	5.6	5.8	4.0	4.7	3.5	4.4	5.4	NA	7.9	6.2	5.8	.25	.5	.6	0.7	0.6	0.5
Sedatives*	NA	9.8	NA	11.0	18.7	17.0	NA	1.2	.4	1.7	2.6	2.8	NA	3.0	NA	5.2	4.8	3.5	NA	.1	.1	0.7	**	**
Tranquilizers*	3.3	9.0	NA	12.2	15.1	15.8	3.3	1.1	2.1	1.7	1.6	2.1	1.9	4.9	NA	7.1	3.6	3.1	0.0	.7	.2	1.0	**	**
Analgesics*	5.0	15.9	NA	11.4	12.1	11.8	1.2	4.2	2.1	2.1	1.0	1.0	3.4	7.8	NA	5.6	3.2	2.7	.5	1.7	1.0	0.9	**	**
Cigarettes	NA	NA	54.1	76.0	76.9	82.8	19.0	21.6	19.5	37.2	39.5	42.6	NA	NA	54.4	80.5	78.7	83.0	16.3	17.2	15.7	32.8	34.6	36.9

*Use patterns for these drug classes are for nonmedical consumption only. ** = Less than 1/2 of 1 percent. NA = Not Available.

NOTE: Regular users are those individuals who have used the substance during the month prior to the survey.

SOURCES OF DATA:

(1) Utah 1987 from University of Utah Survey Research Center telephone Omnibus IV Survey, March 1987. Study commissioned by Utah State Division of Alcoholism & Drugs. Analyses by Dan V. Lebenta.

(2) Utah 1982 from Wasatch Opinion Research Corporation household survey, July 1982-March 1983. Study commissioned by Utah State Division of Alcoholism & Drugs. Analyses by Dan V. Lebenta.

(3) Utah 1979 from Institute for Behavioral Research in Creativity Statewide Prevalence Survey 1979. Study commissioned by Utah State Division of Alcoholism & Drugs. Analyses by Dan V. Lebenta.

(4) Nation - 1979-1985 from National Household Surveys on Drug Abuse. National Institute on Drug Abuse, Division of Epidemiology & Statistical Analysis.

January 1988

RESPONSES TO QUESTIONS FOR MARY LOU BOZICH, SPECIALIST SUBSTANCE ABUSE PREVENTION EDUCATION PROGRAMS UTAH STATE OFFICE OF EDUCATION

1. **ARE THERE ANY LESSONS FROM THE K-12 PROGRAM THAT MIGHT BE APPLIED ON A NATIONAL BASIS?**

Yes. In terms of the lessons learned through our experiences in developing and implementing Utah's K-12 prevention education program, we have identified several things to be essential to the program's success. First, inservice training for teachers is a key to preparing them to utilize the materials effectively and provides some insurance that they will implement the program in their classrooms. Second, the K-12 program is multifaceted in its focus, combining affective education (focus on building self-esteem), development of social competencies/skill building, and drug information in order to address as many of the identified correlates of substance abuse as possible. Third, the K-12 program is an integral part of the schools' health education program, in Utah's case, a mandated part of the Utah State Board of Education's Responsible Healthy Lifestyles Core Curriculum. Fourth, Utah's K-12 program is a multiagency partnership between state and local education, substance abuse, and health agencies, which enables the program to be available for school districts at virtually no cost. Finally, the K-12 program is being evaluated on a longitudinal basis, to assess the effectiveness of the teacher training and the impact of the curriculum on students' drug-related behaviors over time. Longitudinal implementation and evaluation are essential with prevention programs, as such efforts do not generally show an immediate effect, but require long-term implementation to show impact.

In terms of the individual grade level lessons contained in the K-12 program itself, all might be applied on a national basis. Each activity targets one or more of the four program goals: self esteem, knowledge, life skills (decision making, coping, communication, valuing, etc.), and resistance to persuasion skills.

2. **DO YOU THINK THE FEDERAL GOVERNMENT IS CURRENTLY PROVIDING A SUFFICIENT SHARE OF THE COSTS OF RUNNING STATE DRUG PREVENTION AND TREATMENT PROGRAMS?**

Yes, with regard to prevention programs; no with regard to treatment programs.

With regard to prevention programs, I believe the new federal funds allocated to Utah with the passage of the Drug-Free Schools and Communities Act of 1986 have raised federal support to a level almost equal to that of the current state funding. Prior to the new federal funding, most of our efforts were limited to primary prevention/education programs, such as the K-12 Curriculum, which target the general student population. The new federal funding has enabled us to greatly expand education and prevention services to address the needs of more youth, particularly those at risk. For example, the new federal funds are being utilized in Utah not only to enhance and expand the K-12 program and other primary prevention efforts, but also to provide targeted prevention programs for youth characterized by factors which place them at risk for later substance abuse (e.g. children of alcoholics), early intervention programs for youth in early stages of drug experimentation/use, and post-treatment support programs for students returning to schools and communities after undergoing treatment for a substance abuse problem. In addition to the needed increases in federal prevention funding, I also believe it is essential that prevention be the top priority and that the funding be ongoing, and not merely a one-shot response to the national crisis. Prevention remains the most cost-effective means of combatting substance abuse and, in my opinion, the only approach which is having a measurable impact on the problem.

I am not directly involved with the administration or implementation of treatment programs, however, it is my impression that the current federal support for treatment programs is not sufficient. Treatment funding has continuously been subject to cutbacks and/or insufficient increases to meet needs. The treatment population continues to grow and specific groups are seriously underserved. For example, in Utah, the youth population in need of treatment is one of these severely underserved groups. In 1983, it was estimated that 13,000 12-17 year old youths had severe or extreme substance abuse problems and were in need of treatment. During the following year, less than five percent of these youth were able to receive treatment due to lack of services. In 1987, treatment program providers estimated that the number of 12-17 year olds in need of treatment had increased to 20,000.

3. DO THE STATES HAVE SUFFICIENT LEEWAY TO SET PRIORITIES FOR THEIR DRUG PROGRAMS FINANCED IN PART BY FEDERAL BLOCK GRANTS?

No. I am not directly involved in the administration of programs funded by the federal block grant, however, it is my impression that the current categorical requirements of the block grant do not permit sufficient leeway for states to address identified needs and to allocate funds to programs on the basis of prioritized needs. In Utah, the categorical requirements also create some difficulties in the managment of the block grant funds, for example, the separation of alcohol treatment and drug treatment services does not readily correspond to the Utah programs which provide a combination of services under the heading of substance abuse treatment.

Although the categorical requirements are somewhat restrictive in terms of the state's ability to allocate funds on the basis of identified needs, they do provide some assurances that essential services will be provided. For example, I believe that a minimum requirement for prevention is necessary to ensure the provision of such services. Without a minimum requirement, it is conceivable that a state may allocate all or the vast majority of funding to meet treatment needs, without consideration of the need for ongoing prevention services.

4. ARE ALCOHOL AND DRUGS GETTING WHAT YOU WOULD REGARD AS A PROPER SHARE OF THE SET ASIDES UNDER THESE GRANTS?

Yes. I believe the proper share should take into account other resources available to address alcohol/drug and mental health program needs. For example, Utah's medicaid plan currently provides significantly greater coverage for mental health problems than it does for alcohol and drug problems. Given this and other circumstances, it is my impression that the current allocation of sixty percent of the ADMS block grant funds to alcohol and drug programs, and forty percent to mental health is an appropriate one.

5. WOULD IT BE HELPFUL IF THE FEDERAL GOVERNMENT ESTABLISHED AN OBJECTIVE MEASURE OF PROGRAM EFFECTIVENESS WITH RESPECT TO DRUG PREVENTION PROGRAMS FINANCED BY THESE GRANTS?

No. I do not believe it would be feasible for the federal government to develop a single objective measure of program effectiveness to be applied across all programming efforts. Considerable variations exist in program implementations, settings, and target populations. Due to these variations, it is feasible that a program that proves to be effective in one setting may not be effective in another. A single objective measure may lead to the rejection of strategies which offer promise for some populations. I also feel that states should have sufficient leeway to establish their own criteria for effectiveness based upon the nature and extent of the problem and corresponding program objectives.

I do believe, however, that it would be helpful for the federal government to assist states through the devleopment and dissemination of strategies and/or instruments which might be employed to evaluate the effectiveness of prevention programs. I also feel that funding for model demonstration projects, for both process and outcome evaluations of such projects, and for the nationwide dissemination of the findings of such evaluations should be increased toward the goal of expanding and refining our knowledge about what works in prevention.

6. IS TREATMENT GETTING TOO MUCH EMPHASIS IN TODAY'S DRUG PROGRAMS TO THE DETRIMENT OF PREVENTION?

No. I do not believe that treatment is receiving undue emphasis. If anything, treatment is severely underfunded. It is my opinion, however, that the one-shot supply reduction strategies, while perhaps part of the solution, are receiving emphasis to a degree which threatens to de-emphasize the important long-term impact of prevention. In order to effectively combat the drug abuse problem, both demand and supply strageties are essential and must be combined in a comprehensive, community-wide effort including education, prevention, intervention, treatment, and law enforcement. No single strategy implemented alone will be effective. Prevention is the long-term answer to the problem, and I feel that education and prevention should, therefore, be the number one priorities and should receive the major and an ongoing emphasis beginning at the earliest possible time in an individual's life. As a nation, we must make a commitment to being proactive in our fight against drug abuse and not place undue emphasis on reactive strategies which are extremely costly not only in terms of dollars but in terms of human health, potential, and life.

7. WITH RESPECT TO IV DRUG ABUSE, WHAT ROLE CAN TREATMENT PLAY TO KEEP AIDS FROM EXPANDING EVEN FURTHER THROUGH THE DRUG CONSUMING COMMUNITY?

I believe that treatment programs can play a critical role in preventing AIDS from expanding through the drug consuming community in three specific ways. The first is through education. Programs may educate individuals in treatment about the transmission of the virus through sharing infected needles and may multiply this effort by encouraging those in treatment to pass the word among other IV drug users. The second is through the reduction or elimination of the user's demand for drugs. Much of the spread of AIDS among IV drug users is due to the amount of drug use. By reducing or eliminating use, the probability of an individual's utilizing an infected needle is correspondingly reduced or eliminated. In addition, by reducing or eliminating use, the user's ability to make responsible decisions with regard to engaging in behaviors which are correlated with the transmission of the disease (e.g., sharing infected needles and sexual behavior), is improved and such behaviors are less likely to occur. The third way in which treatment can prevent the spread of the disease is by consistently testing all clients for the virus, either as part of the program or through a referral to the health department, and then providing relevant education and/or counselling services.

8. YOU OPPOSE THE CONCEPT OF A DRUG CZAR AS LIKELY TO TIP THE BALANCE OF THE DRUG CONTROL EFFORT EVEN FURTHER TOWARD THE SUPPLY SIDE. WOULD YOU FEEL MORE COMFORTABLE WITH THIS CONCEPT IF THE SO-CALLED DRUG CZAR WERE DIRECTED THROUGH THE ENABLING LEGISLATION TO PERFORM CERTAIN SPECIFIC FUNCTIONS ON THE DEMAND SIDE?

Yes. My opposition to the concept of a drug czar was specifically in response to the proposal that the czar be somehow affiliated with a federal Bureau of Justice Assistance and that programs be coordinated through state justice assistance agencies. While I am not completely informed as to the role of the proposed czar, I do have concerns about the role becoming primarily focused on supply side or law enforcement issues. I do not oppose the concept of more centralized coordination at the federal level. I believe that the various agencies which are currently administering drug funds are not coordinating efforts as effectively as they need to if we are to impact the problem. I would be comfortable with the concept of a drug czar only if the role was one of leadership and advocacy for the full continuum of alcohol and drug programs including both demand and supply reduction strategies. I would also hope that the national priorities for which the czar provides advocacy would be set with sufficient input from and in cooperation with the states.

9. IF YOU THINK THIS CONCEPT WOULD WORK, WHAT DEMAND-REDUCING ACTIVITIES SHOULD BE REQUIRED UNDER THE BILL?

If the concept of a drug czar is one of creating more centralized coordination, leadership, and advocacy for drug programs at the federal level, and for setting national priorities in cooperation with the states, I believe it would be a workable one. I would recommend that each state be required to work toward the establishment of a full continuum of prevention and treatment (demand reduction) programs in order to receive funds. In terms of the Utah State Board of Substance Abuse Continuum of Services, these programs would include school and community-based prevention services in the following areas: primary prevention and education programs for the general population, including a comprehensive K-12 prevention education curriculum in all schools; targeted prevention programs for individuals who, because of certain identifiable characteristics, are considered to be at risk for substance abuse; early intervention programs for individuals who are in the early stages of experimentation or use of substances; and post-treatment support programs for individuals returning to school, community, or work environments. Programs should be broad based and involve parents, educators, youth, and appropriate professionals and community agencies working in cooperation toward identified goals. In addition to prevention programs, appropriately designed treatment services for identified population groups should be established. Demand reduction programs should also be closely coordinated with law enforcement and other supply reduction efforts toward a comprehensive approach to the problem.

The **Chairman**. Thank you very much. That was very helpful.

Let me just go through quickly. Dr. Johnston, even though there has been some decline in use of the substances you identified earlier, cocaine and marijuana, do you find there is increase in the use of alcohol among the students?

Dr. **Johnston**. Originally, many people predicted that, as there was some decline in the illicit drug problem, we would see alcohol come in and replace it. We have not found evidence of that. In fact, for a few years there was some decline in parallel in alcohol use.

The **Chairman**. I'd take a look at Massachusetts on that. Drug-free schools have had some positive effect, and the studies by the Department of Mental Health up there indicated it just hadn't been as effective in terms of alcohol. I would be interested if you could review the material; letting me know your conclusions.

What evidence is there that school curricula on drugs actually work?

Dr. **Johnston**. I think there is a kind of cumulative evidence in the sense that we have asked each graduating class to what extent they have been exposed to school curricula dealing with drugs, and also their judgment about how those curricula experiences had influenced their inclination to use drugs.

It is noteworthy that about a quarter of virtually all recent graduating classes said they had no drug abuse curricula, at least none that they could remember, and said so on the questionnaire. So I think there is clearly a need for more.

Many felt that it had some positive value, however. I think in the aggregate it still is not as impressive as it might be.

I think we have to recognize that in this area of social intervention, like most, many of the "good" ideas that we try out aren't going to work; it is just part of the reality. So I think we need to take an experimental approach, where we try a number, and figure that we are lucky if 40 percent work. With good evaluation, we will know which 40 percent they are, and we can expand those, and stop wasting resources on the others that don't. That is one of the reasons I was saying I think it is critical that we have a major evaluation effort as part of our prevention efforts.

The **Chairman**. Mr. Levant, what are the key ingredients the drug prevention programs must have to be effective?

Chief **Levant**. The key to it is that it is an educational program one semester in duration that teaches children not a slogan or not a concert or not a one-shot media hype type of an event, but it teaches them exactly how to avoid the peer pressure that our research tells us is the first involvement of a child with narcotics. It teaches a child how to say no in a way that they can adapt to their own personality.

The **Chairman**. You have got it all over California now?

Chief **Levant**. Eighty-five cities in California; 38 States; 501 different cities throughout the United States; 25,000 classrooms as we speak.

The **Chairman**. What is the advantage of having law enforcement personnel do it versus educators, or is there an advantage?

Chief **Levant**. Nationally, the advantage has been that the law enforcement officers—who are specially-trained, I might add, before they teach the program—have the credibility with the children to respond to their very surprisingly sophisticated questions about narcotics. I am sure you would be amazed at the level of sophistication that a fifth-grader has in any metropolitan center in the United States about drugs. The teachers simply don't have the credibility, although they do have the skills.

In many of the classrooms across the United States, the schoolteachers help the officers in the DARE Program, and that is something we welcome.

The **Chairman**. For far too long, it seems that the educators and the law enforcement were at-odds. You can perhaps understand the reasons for that—teachers wanted to keep the law enforcement personnel away from their schools, and there was some tension. But clearly, where you have been able to see them come together and work in a cooperative way, as we are increasingly seeing in my own State, it does have a positive impact.

Let me ask Ms. Bozich, in the early grades, say, kindergarten through third grade, what does the program consist of?

Ms. **Bozich**. In the early elementary years, the program is very much focused on developing positive self-esteem and healthy life skills; helping children to develop coping skills, decisionmaking skills; to understand very elementary concepts about substances—maybe the concept of poison, or that drugs and things that we use in our daily lives, such as cleaning solvents, may have very positive and also very negative uses if they are used in a very wrong way.

But primarily, on developing self-concept, recognizing the importance of friendships, understanding, communicating, helping others, asking for help when it is needed and so on—it wouldn't look like a drug prevention program to someone who didn't understand what the key ingredients of successful prevention are.

The **Chairman**. Well, I want to thank all of you for your comments and suggestions. As you can probably figure out in the course of the hearing, the education component is going to be a major aspect in the fashioning and shaping of any legislative proposal, and I think you have given us a lot of good ideas and suggestions about how that ought to be fashioned and shaped. So we want to thank you all very, very much. We appreciate it.

Our next panel will be Dr. Robert Newman, President of Beth Israel Medical Center; Shirley Coletti, Founder of PAR, a comprehensive drug program in Florida; and David Mactas, President of Marathon House, a residual treatment community.

We will start off with Dr. Newman.

STATEMENTS OF DR. ROBERT G. NEWMAN, PRESIDENT, BETH ISRAEL MEDICAL CENTER, NEW YORK, NY; SHIRLEY COLETTI, EXECUTIVE DIRECTOR, OPERATION PAR, INC., PINELLAS PARK, FL; AND DAVID J. MACTAS, PRESIDENT, MARATHON HOUSE, INC., PROVIDENCE, RI

Dr. **Newman**. Thank you very much, Senator. I will be brief, in part because the message that I wish to convey is a very simple one. Basically, it is that immediate treatment on demand must be available to every single addict who wants help and needs help in giving up his or her narcotic dependence.

This is not only a very simple message; it is also one that is redundant, based on the testimony and on the comments that have been made earlier today. A number of Senators, and also Reverend Jackson and others, referred to the long waiting lists that exist throughout the country. This is not just a New York City or a New York State phenomenon. Right now in Salt Lake City, the major program is filled to capacity and has stopped intake. In Boston, Senator, there are right now, I am told, 1,200 addicts using heroin on the streets who have applied for treatment and whose only response has been to have their names put on a waiting list.

Very significantly, there was recently in the State of Massachusetts an increase in funding for expansion of treatment programs. That expansion took place, but in fact, the waiting lists are even longer today than they had been before this expansion, because as frequently happens, word on the street got out that the treatment programs were accepting new patients, and that immediately caused a very substantial increase in the number of applicants who sought treatment.

One has to ask what the problem is, since obviously, we are all agreed that treatment has to be made available. Indeed, I can't imagine that you would have been able to find a witness who would testify that treatment on demand is not necessary—someone who would say, "let those folks stay out on the street, shooting dope; there is no need to provide help to them." So clearly, everybody agrees there must be treatment, and yet, as far as I know, there isn't a single State or city in our entire country that indeed can say, "If you or a friend have an addiction problem, immediate help is available, and this is the number you call to enroll promptly in treatment."

One has to ask why there is this disparity between what everybody knows to be essential and what the actual situation is.

I suspect part of the answer lies in a sense of resignation because of the enormity of the problem and an unwillingness to do anything because one feels one just can't get on top of the overall problem and solve it once and for all.

There is also the myth—and it truly is a myth—that addicts don't want treatment. We know from the waiting lists, we know from the desperate demand of people who apply for treatment, that there is a very substantial proportion of the addict population that not only expresses a willingness to accept help, but has a desperate motivation to enroll in treatment and get help in order to overcome addiction.

Another major myth is that treatment doesn't work; that is absolutely untrue. There are a host of treatment modalities, approaches, that have been employed for decades. Methadone happens to be the one that I am most familiar with. But we know that treatment is in fact very effective with a very substantial number of patients, in terms of overcoming drug dependence, and also more recently in terms of lessening the very high-risk behavior that is associated with the spread of AIDS.

A key question, obviously, is we have to do in order to make treatment on demand change from a slogan to a reality. Clearly, money is needed, personnel will be needed, facilities are needed. I very firmly believe, though, that all of those needs are secondary.

The major need, the major factor that has been lacking throughout our country, has been a commitment, a commitment that we simply will not tolerate continuation of a situation where addicts who want treatment are turned away when they apply for help. The commitment that this will no longer be tolerated has to be made. If it is not forthcoming spontaneously, I do believe it has to be imposed. I am not sure if it has to be imposed by the Judiciary or by the Executive Branch or by Congress, but somebody has to say, "you must come up with alternative ways to end this irrational situation that we have today."

Very briefly, two analogies where precisely such a commitment was imposed successfully. First in New York City: several years ago it was widely recognized there was insufficient shelter to house the homeless in the city. A judge who heard all of the reasons why adequate expansion was a problem—money, community opposition, staffing and so on, simply said, "Mr. Mayor, that's your problem. I am telling you, you must be able to accommodate every single homeless person in New York City who asks for shelter."

And very shortly after that commitment was imposed, in fact, everybody who wanted shelter could get it. The system is not optimal, but certainly nobody would suggest that it would be better to have families and adults and children put on a waiting list when they apply for shelter.

Very recently, just this week, a judge in Texas told a hospital there that had developed a waiting list for a new experimental form of AIDS treatment that it had to accommodate every single person who applied. The hospital argued—I am sure very correctly—that there was a personnel problem, they couldn't get enough staff, there was a money problem. But the judge was not deterred, and simply ruled:"You must accommodate everyone who applies."

I would urge, Senator, that this Committee insist upon that commitment being made in the area of addiction treatment as well. One of the tragedies is that the responsible governmental agencies at the Federal as well as State levels have never even been asked the question, "How can you provide immediate treatment on demand." As far as I know, no governmental agency has ever claimed that it is impossible to do so. But the question has never been asked; an answer has never been demanded, and at the very least, that should happen, and it should happen at once.

Thank you, Senator.

[The prepared statement of Dr. Newman and responses to questions submitted by Senator Kennedy follows:]

ADDICTION TREATMENT ON DEMAND

THE NEED FOR COMMITMENT

Testimony before the
Senate Committee on Labor and Human Resources

June 16, 1988
Washington, D.C.

Robert G. Newman, M.D.
President, Beth Israel Medical Center
New York, New York

INTRODUCTION

It is a privilege to be asked to testify before this Committee on the need to provide immediate treatment, on demand, to every single addict willing to accept help in overcoming narcotic dependence. Beth Israel Medical Center, which I have the honor to serve as Chief Executive Officer, has been providing substance abuse treatment longer, and on a far greater scale, than any voluntary hospital in the United States. Over 7,600 former heroin addicts are receiving methadone maintenance treatment in clinics operated by Beth Israel. In addition to this out-patient program, the Medical Center has 180 beds in discrete units dedicated to the treatment of chemical dependency and associated diseases.

Today, a new "associated disease" - the Acquired Immune Deficiency Syndrome - has joined the list of other illnesses which threaten the lives of addicts and those close to them, and which impose enormous costs for our society. In New York City addicts already constitute the largest segment of the population afflicted by AIDS. In cities like San Francisco, where just a few years ago the disease was found almost exclusively in gay men, the proportions are changing rapidly. It is not unlikely that addict-related AIDS cases will soon represent the majority of cases world-wide.

It is easy to become overwhelmed by a sense of gloom and hopelessness by the enormity, and the complexity, of the problem of heroin addiction. The fact is, however, that a great deal can be done - and therefore must be done. My specific plea today is that all forms of addiction treatment be expanded promptly. We know that in cities across the country that there is a desperate unmet need and demand for treatment. And we know that treatment - through methadone maintenance and through other modalities - can have a major impact on controlling narcotic addiction. The time to act is now!

Let's review the facts:

1. There are a great many individuals who inject heroin several times each day. It does not matter precisely how many such individuals there are. What does matter is that they exist, that they inject themselves with illicit drugs two, three or more times each day, and that in doing so they put their lives and the lives of others - addicts as well as non-addicts - in mortal jeopardy.

2. Among these addicts there are many who want to give up heroin use, and need help to do so. It does not matter

how large a proportion of the addict population these individuals represent, nor what motivates them to discontinue injection of the drug, nor why - or even whether - they can not do so on their own. The fact is that such addicts exist, that they themselves perceive the need for help, and that without help they will almost certainly continue to take heroin.

3. It is the rule rather than the exception that efforts by addicts to obtain treatment are thwarted. In cities throughout the United States, addicts who desperately want treatment are "placed on waiting lists" - a euphemism for being forced to continue drug use because the programs to which they apply are full.

METHADONE TREATMENT - ONE COMPONENT (AMONG MANY) OF THE EFFORT TO CONTAIN ADDICTION

Clearly, narcotic addiction represents a problem which has economic, political, medical and social aspects, and whose dimensions extend beyond any geographical boundaries. It is impossible to have a major impact on - let alone to solve - the problem by relying entirely on domestic law enforcement, on economic sanctions on producer nations, on efforts of customs authorities to interdict in-coming supplies of drugs, on efforts to prevent the uninitiated from experimenting with drugs, or on treatment to help those already addicted. All of these efforts are essential, and it would be counter-productive to allocate budgetary resources to any one of these approaches, to the exclusion of others. Applying a military metaphor: it would be absurd for a Secretary for Defense to insist that reliance be placed entirely on the Navy, to the point that air and ground forces be dismantled. Just as is true of the different military services, those involved in one or another of the components of the effort to deal with addiction do not represent competing interests, but complementary forces which must be applied jointly.

Having acknowledged the many different elements which are crucial to an effective "war on drugs," I readily acknowledge that my own experience and expertise are narrowly defined. I am a physician, and my role for the past 18 years has been to provide treatment to as many addicts as possible. More specifically, the programs with which I have been involved have utilized methadone, both for short-term detoxification and for long-term "maintenance."

Methadone maintenance has been extraordinarily successful in reducing heroin addiction and its related ills in this country and throughout the world. Its success has been documented time and again, in communities in Europe, Asia, Australia and North

America. Based on this world-wide experience, methadone maintenance over the past 22 years has won increasing acceptance by the medical community and the public for its effectiveness in treating heroin addiction, and for the numerous associated benefits to society at large. Through methadone maintenance treatment, tens of thousands of former heroin addicts have been freed from dangerous, illicit drug use, and have been enabled to resume normal, healthy, productive lives. They are in our community today as successful members of society. They have families, jobs and homes. You cannot, in fact, distinguish the majority of them from other members of the community.

Nevertheless, many misconceptions persist, and there continues to be intense controversy over this therapeutic approach. Tragically, while the debate goes on, people are dying! For the vast majority of addicts, the alternative is methadone treatment, or nothing! Accordingly, there is only one question which really matters: is the provision of methadone treatment better for the patient and for the society than the continued use of heroin?

I cannot believe that there exists among the members of the Committee suspense regarding my answer to the rhetorical question I have posed. To me it appears to be absolutely self-evident that the answer must be an emphatic and unqualified yes! Surely nothing can be worse than refusing addicts treatment -any treatment - as an alternative to continued heroin use. I say this despite the acknowledged limitations which apply to methadone treatment as well as to every form of addiction treatment which has ever been introduced. It is difficult to imagine what criticism of methadone treatment, justified or unjustified, could lead to the conclusion that addicts and society are better off if junkies are left to shoot heroin.

METHADONE TREATMENT AND AIDS

But what of the newest calamity associated with narcotic addiction: AIDS? What impact can methadone treatment have on this epidemic, which increasingly affects intravenous drug users, and which is spread by them to the general population? In fact, it can have a very major impact!

For the drug user who is still sero-negative, and thus presumably not yet infected, enrollment in a methadone treatment program decreases substantially the likelihood of becoming infected. This has been demonstrated in the United States, where it was found that ". . . fewer than 10% of heroin addicts who entered methadone maintenance treatment programs in New York City prior to 1978 are antibody positive for the human immunodeficiency virus, compared with 60% of heroin addicts who did not enter treatment." (Schuster, 1987) Similar evidence of the effectiveness of methadone treatment in lessening the risk of contracting AIDS has been reported from Italy as well. (Tidone _et al_, 1987)

Nor are the benefits of methadone treatment with respect to AIDS restricted to those former intravenous drug users who were sero-negative at the time of enrollment. It appears clear that repeated exposure to the human immunodeficiency virus, as well as exposure to a variety of infectious agents, increases the likelihood that a sero-positive individual will develop (and ultimately die from) AIDS. (DesJarlais et al, 1987) Methadone treatment dramatically reduces such high risk behavior. (Abdul-Quader _et al_, 1987)

It also has been demonstrated that former addicts, once engaged in the clinical milieu of a methadone clinic, are responsive to educational efforts to lessen high-risk sexual behavior. My own hospital, Beth Israel Medical Center in New York City, has made free condoms available to its patients along with health education regarding the mechanisms of spread of the AIDS virus. In less than one year, over 700,000(!) condoms were distributed to our 7,600 patients. Obviously, methadone patients use condoms for the same purpose as anyone else, and the protection they provide their partners in doing so is enormous.

THE NEED FOR ACTION

The field of addiction treatment has for years been characterized by polarization and controversy. This is not all bad, since the intensity with which providers of service advocate a particular approach reflects in large measure an uncompromising dedication and commitment which is to be commended. But today, as never before, it is imperative that we stop arguing over irrelevancies, and focus instead on how to lessen the pain, suffering and costs associated with addiction. Perhaps the tragedy of AIDS will be the impetus for change, as we recognize the fact the narcotic addicts are the second largest group in our society to be afflicted, and the number one group from whom this disease is being spread to the heterosexual - and infant - population.

In the face of this reality, it is simply mind-boggling that throughout the United States, every day and in every major city, as a matter of course, addicts are denied access to treatment - treatment which they desperately want, and which we know can help them. Thousands of these addicts continue to inject heroin several times each day, and thereby pose a fatal threat to themselves and impose enormous costs on the health, well-being and safety of every member of our society. To condemn them - and ourselves - to the continued devastation associated with heroin addiction by refusing to make treatment available is a terrible mistake. Treatment for all is a realistic goal. It can be achieved. It must be pursued!

So what's missing? What can - and must - Government do to replace rhetoric with action, to make the slogan "immediate treatment on demand" a reality for every single heroin addict who desires to overcome his or her dependence on illicit drugs? For sure, money is part of the answer - funding to allow expansion of methadone treatment and other therapeutic efforts which offer help and hope. Staffing likewise is a problem - particularly at a time when severe shortages of nurses and other health-related personnel are being experienced throughout the nation. But these hurdles are relatively minor. The key ingredient which is lacking, and which is critical to our ability to make treatment on demand possible, is commitment. It is the resolve by Government to refuse to tolerate further the status quo, the existence of "waiting lists," the inability to reach out and encourage those addicts who do not come forward spontaneously to do so in their own interests, and in the interests of their communities.

Let me draw an analogy with the plight of the homeless in New York City. For years it was recognized that the City was unable to accommodate all the homeless who wanted and needed shelter.

Without question, the obstacles to an expanded network of facilities were substantial, and involved funding, staffing and - perhaps most difficult of all - opposition by communities to the establishment of shelters in their neighborhoods (the similarity to the issues facing drug treatment programs is obvious!). These obstacles were real, and they were great, and they allowed even the most committed Government officials to rationalize inaction. And yet, the Federal judge hearing a case brought by the Coalition for the Homeless was undeterred, and simply demanded that the City of New York provide refuge from the streets to all who sought it. Faced with this judicial fiat, the City complied.

The facilities for the homeless which exist in New York City today are far from ideal. There are valid criticisms of over-crowded apartments, huge armories with endless rows of cots which preclude any semblance of privacy, problems of cleanliness and security, and inadequate attention to the special needs of small children. But even the harshest critics would not dream of suggesting that homeless men, women and children be left on the streets of the City, their names duly placed on "waiting lists," until a "slot" becomes available. Precisely this absurd, unthinkable, unconscionable policy, however, governs the availability of treatment services to heroin addicts from one end of our great country to the other.

An analogy even closer to the issue at hand was reported this very week. A judge has ordered a Texas hospital to end waiting lists for AIDS treatment, despite the contention (which undoubtedly is true) that problems of physician recruitment and lack of funding face the program. In the words of the judge: "To whom must the victim turn? The public must intervene or else adopt a policy that says, 'Let them die because we can't afford them.' Such a result is not tolerable in a society that for over 200 years has prided itself on placing human values first." (Little, 1988) The same words, the same principle and the same appeal to the conscience of America apply to waiting lists for treatment of narcotic addiction.

CONCLUSION

It is my hope, and my plea, that this Committee will do everything possible to elicit a firm and unequivocal commitment by our Government to ensure immediate access to treatment to all narcotic addicts. If humanitarianism does not move us, then self-interest must.

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Robert G. Newman, M.D.
PRESIDENT

June 28, 1988

The Honorable Edward M. Kennedy
United States Senator
Chairman, Committee on Labor and
Human Resources
Washington, D.C. 20510

Dear Senator Kennedy:

Thank you for your letter of June 20, 1988, regarding the testimony I gave before your Committee on June 16. Only one of the questions appended to your letter is relevant to my testimony, and that is with respect to addiction treatment program effectiveness.

I must point out first that addiction is a disease which is difficult to define, whose causes are unknown, and which no one anywhere in the world, through whatever techniques, has been able to "cure." Having acknowledged the limitations, however, I hasten to add that addiction also is a disease for which many forms of treatment are effective, and the specific treatment approach with which I am most familiar - methadone maintenance - can be effective on a very massive scale.

- "Success" clearly is a function of being able to retain patients in treatment. Methadone does so to a greater extent than any other modality. Approximately two-thirds of all patients receiving even a single dose of methadone are retained in continuous active treatment for at least one full year.

- With regard to the primary drug of abuse - heroin - the impact of methadone treatment is dramatic indeed. Almost from the very beginning of treatment, heroin use by 90% or more of the patients ceases.

- While methadone has no pharmacological impact on the use of non-opiates, it has been demonstrated that with added time in treatment the use of other drugs decreases. Nevertheless, it must be recognized that cocaine abuse, which is so rampant throughout America today, is a major problem for which neither methadone maintenance nor any other treatment modality has any magic solution.

AFFILIATED WITH MOUNT SINAI SCHOOL OF MEDICINE. MEMBER OF UJA-FEDERATION OF JEWISH PHILANTHROPIES.

- It has been repeatedly demonstrated in programs throughout the world that methadone treatment has a tremendously positive impact on the general health of former heroin users. The impact of methadone treatment on reducing the likelihood of exposure to the AIDS virus has also been documented and reported in America as well as overseas.

- With regard to improvement along social parameters such as employment and criminality, methadone treatment again has been found consistently to be enormously effective.

Although there are limitations of treatment in this as well as in most medical fields, the real frustration - and the shame - in connection with addiction treatment is that it is being denied entirely to tens of thousands of addicts who desperately want and need help. For these countless individuals, as well as for the communities that share the price of their continued addiction, the tragic reality is that when they come forward to seek admission to treatment programs, they are told to go back to the streets and keep shooting drugs for weeks or months until a space is available. Nothing - absolutely nothing - can justify tolerating this absurd situation. I do hope that the Committee will do its best to demand that the responsible governmental agencies at the Federal and State levels address this situation, and do so at once.

Again, my thanks for the opportunity to testify and to respond to this question.

Sincerely yours,

Robert G. Newman, M.D.

The **Chairman**. Ms. Coletti.

Ms. **Coletti**. Senator Kennedy, I thank you and your Committee for the opportunity to come today.

I come to you with a little bit of a different perspective in that I represent an organization called Parental Awareness and Responsibility. Our program is a little over 18 years of age. We started from concerned parents who realized there were problems in our community, developed a grassroots effort to educate parents; $10,000 in donations 18 years ago have let to what now is a $5 million budget. We treat at any given time over 400 people a day in a variety of modalities of treatment, from adolescent residential treatment to therapeutic community to methadone maintenance to a survival program for parents, school-based prevention programs. We are truly a multi-modality comprehensive program.

That organization began, as I said, 18 years ago, and this year we will see in prevention, treatment and education, over 28,000 people in our program throughout the Tampa Bay area.

I know time is short, so I think I am going to spend it where it is best, and that is, I want to talk about the Office of Substance Abuse Prevention.

I think in the 18 years I have been involved in the drug abuse fight, the Office of Substance Abuse Prevention that was brought into being by Congress two years ago is probably the most effective program.

The Congress funded it, $36 million. Next week, Operation PAR—and you have the invitation before you—will open a newly-funded program from OSAP. This program is designed to treat cocaine babies and the children of substance abusers. We will be working with a therapeutic day care center as well as residential treatment for the mothers, and fathers, where they are involved.

OSAP needs Congressional support. OSAP responded to 900 grants this last grant period, and 131 programs were funded. They are grassroots programs. They are not heavy-duty research programs. They are not university-based programs. But they are representative of what I think is needed throughout this country.

The criminal justice aspects of community programs are vital. For example, in addition to our therapeutic community, Operation PAR has an in-jail treatment program. Our therapeutic community observes criminal offenders. Over the years, we have been keeping very good statistics. Since 1975, of the 100 prisoners that were referred to our Therepeutic Community by the Florida Department of Corrections, 77 of those prisoners are non-recidivists. Nationally, I think the recidivism rate is anywhere from 60 to 70 percent, especially for drug-related offenders. We have only 27 percent who have been recidivists. That is a very impressive number.

Another aspect that I think Congress needs to deal with is the importance of training the employees and personnel in the areas of drug prevention and treatment programs. As we make more funds available, obviously, we need more fellowships, we need more grants, and we need more sponsorships to encourage physicians, social workers, nurses and people who wish to become involved in the field of addiction.

Communities can respond, communities can expand. Dr. Newman just spoke of treatment on demand. I do not come from just a methadone treatment modality. I represent an adolescent residential treatment program, a 30-bed facility with a waiting list; a therapeutic community, a 100-bed facility, with a waiting list of 250 people ready to come into our program.

The importance, though, of a community responding to the drug abuse problem is demonstrated in that our County has just donated 14 houses to us. The County is paying the expenses of moving those houses onto our property so that we can expand our residential treatment program. A program like PAR needs the money for staff and needs money for expenses for those programs.

I know time is brief, but just let me say that I appreciate everything you have done in the field of drug abuse, and I appreciate your Committee's work. I don't believe that we have really declared war. I think that programs like Operation PAR can be models, and they can be replicated very easily throughout the country.

Thank you so much.

[The prepared statement of Ms. Coletti and responses to questions submitted by Senator Hatch follow:]

TESTIMONY
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JUNE 16, 1988

UNITED STATES SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

GOOD MORNING. I AM PLEASED TO BE PRESENT THIS MORNING TO PROVIDE INFORMATION ABOUT DRUG ABUSE FROM THE PERSPECTIVE OF A COMPREHENSIVE SERVICE ORGANIZATION. OPERATION PAR (PARENTAL AWARENESS AND RESPONSIBILITY) BEGAN PROVIDING DRUG ABUSE TREATMENT, EDUCATION, AND PREVENTION SERVICES TO THE TAMPA BAY AREA NEARLY TWO DECADES AGO. PAR IS A NON-PROFIT COMMUNITY BASED PROGRAM. FUNDING IS RECEIVED FROM VARIOUS SOURCES THAT RANGE FROM LOCAL, STATE, AND FEDERAL FUNDS TO UNITED WAY, DONATIONS, AND CLIENT FEES. ANNUALLY, PAR PROVIDES SERVICES TO OVER 28,000 PEOPLE IN AREAS RANGING FROM PREVENTION TO RESIDENTIAL TREATMENT.

WELL ORGANIZED COMMUNITY-BASED DRUG ABUSE PROGRAMS DO WORK. OPERATION PAR HAS MADE A SIGNIFICANT IMPACT ON THE DRUG ABUSE PROBLEM FACING OUR COMMUNITY. THE PAR MODEL THAT PROVIDES COMPREHENSIVE SERVICE DELIVERY FOR A RANGE OF ISSUES, ENABLES OUR COMMUNITY TO ADDRESS THE NEEDS IDENTIFIED AS A RESULT OF DRUG ABUSE. I THINK AT THIS POINT IT IS IMPORTANT TO UNDERSTAND THAT THE MAJORITY OF AMERICAN COMMUNITIES FACING THE CRISIS OF DRUG ABUSE ARE IN MIDDLE TO SMALL COMMUNITIES. ALTHOUGH THE PROBLEMS FACED BY CITIES LIKE CHICAGO, NEW YORK, MIAMI, DETROIT AND LOS ANGELES AND SMALLER COMMUNITIES ARE SIMILAR IN DEFINITION THEIR RESPONSES ARE QUITE DIFFERENT.

IN THE PAST TWENTY YEARS PAR HAS BUILT A SYSTEM OF DRUG ABUSE SERVICES THAT ADDRESSES THE VARIOUS LEVELS OF NEED EXPERIENCED BY A COMMUNITY FACING THE DRUG ABUSE CRISIS. THE KEY TO THE SUCCESS OF THE OPERATION PAR PROGRAM IS THAT WE HAVE UTILIZED THE KNOWLEDGE FROM THE VARIOUS MODALITIES TO MAKE SIGNIFICANT CONTRIBUTIONS TO OUR COMMUNITY AND TO THE FIELD OF DRUG ABUSE PREVENTION AND TREATMENT. AN EXAMPLE IS OUR CHILD DEVELOPMENT AND FAMILY GUIDANCE CENTER. NEXT WEEK, OPERATION PAR WILL OPEN ONE OF THE FIRST OF ITS KIND OF SERVICES. THE CENTER WILL PROVIDE SERVICES FOR THE CHILDREN OF SUBSTANCE ABUSERS. SPECIFICALLY, INFANTS AND BABIES EXPOSED OR ADDICTED TO COCAINE FROM BIRTH. THE CENTER WILL PROVIDE SERVICES TO THE MOTHER TO ADDRESS HER ADDICTION, BUT WILL ALSO PROVIDE DEVELOPMENTAL SERVICES TO THE CHILDREN TO MEET THEIR SPECIAL NEEDS.

THE NEED AND THE DRIVING FORCE BEHIND THE DEVELOPMENT OF THIS PROGRAM CAME FROM TWO DIFFERENT PAR PROGRAMS. IN RECENT YEARS STAFF AT OUR ADULT AND ADOLESCENT RESIDENTIAL CENTERS HAVE NOTICED THAT A SIGNIFICANT PERCENTAGE OF THE CLIENTS INVOLVED IN TREATMENT HAD A FAMILY HISTORY OF DRUG USE. SOME HAD EVEN BEEN INTRODUCED TO DRUGS BY THEIR PARENTS, EITHER BY EXAMPLE OR THROUGH DIRECT INVOLVEMENT. IT BECAME EVIDENT THAT MANY WERE SECOND OR EVEN THIRD GENERATION SUBSTANCE ABUSERS. ANOTHER DESIRE FOR PROGRAMMING FOR THE INFANTS AND SMALL CHILDREN WAS VOICED BY STAFF IN OUR PREVENTION PROGRAMS. OFTEN STAFF WORKED WITH MANY CHILDREN IN THE FOURTH OR FIFTH GRADES THAT EXHIBITED BEHAVIORS THAT COULD BE TRACED BACK TO SOME LEVEL OF SUBSTANCE ABUSE IN THE HOME. AS THESE FEELINGS AND CONCERNS BEGAN TO BE RAISED BY STAFF, PLANS WERE FORMALIZED TO ADDRESS THIS SERVICE NEED THROUGH THE DEVELOPMENT OF THE CHILD DEVELOPMENT AND FAMILY GUIDANCE CENTER. THERE ARE MANY OTHER EXAMPLES OF HOW THE NATURE OF THE PAR ORGANIZATION AND ITS COMPREHENSIVENESS HAS LED TO THE DEVELOPMENT OF SPECIALIZED SERVICES TO MEET COMMUNITY NEEDS.

OVER THE YEARS, I HAVE HAD OCCASION TO TRAVEL THROUGHOUT THE

COUNTRY AND SPEAK TO A WIDE VARIETY OF GROUPS ABOUT DRUG ABUSE AND COMMUNITY RESPONSE. ONE QUESTION IS ALWAYS ASKED, "HOW DO WE DEVELOP A PAR?" THE QUESTION HAS BOTHERED US. MORE SPECIFICALLY THE PEOPLE ARE ASKING HOW DO YOU DEVELOP A COMMUNITY RESPONSE TO DRUG ABUSE. COMMUNITIES ACROSS THE COUNTRY HAVE MOST OF THE SERVICES OFFERED BY OPERATION PAR, BUT THE INDEPENDENT VARIABLE IS THAT OF CONSISTENCY AND COMPREHENSIVE APPROACHES TO COMMUNITY NEEDS.

TODAY I WOULD LIKE TO FOCUS MY REMARKS ON TWO MAJOR POINTS: 1) WE ARE WINNING SOME BATTLES IN THIS WAR ON DRUGS AND 2) THAT OUR SUCCESS IN THIS WAR ON DRUGS WILL BE DIRECTLY CORRELATED TO OUR ABILITY TO ENSURE COMPREHENSIVE APPROACHES TO THE ISSUE.

DRUG ABUSE, AS WE ALL KNOW, IS A PROBLEM WITH MANY FACETS. OR A WAR, IF YOU WILL, FOUGHT ON MANY FRONTS. TODAY WE HEAR A LOT ABOUT "DEMAND REDUCTION". BUT IF WE ARE REALLY TO MAKE SIGNIFICANT PROGRESS WE NEED ALSO TO FOCUS ATTENTION ON THE CASUALTIES OF THIS WAR AND FOCUS MORE ATTENTION ON TREATMENT.

ON THE FIRST TOPIC, WE HAVE WON MANY BATTLES IN THE WAR ON DRUGS. YOUNG PEOPLE ARE BEGINNING TO UNDERSTAND THAT DRUGS ARE NOT A "RITE OF PASSAGE". THAT DRUGS CAN RUIN YOUR LIFE. DAILY, PEOPLE ARE SEEKING HELP FOR THEIR PROBLEMS, MANY VOLUNTARILY. THE COMMUNITY IS TAKING AN ACTIVE ROLE IN SUPPORTING AWARENESS AND PREVENTION CAMPAIGNS LIKE "SAY NO TO DRUGS". THESE EFFORTS HAVE HAD A POSITIVE EFFECT ON OUR ABILITY TO PROVIDE TREATMENT TO THOSE IN NEED. PEOPLE HAVE BECOME AWARE OF THE ENTIRE SPECTRUM OF ISSUES RELATED TO DRUG ABUSE.

ON THE SUPPLY SIDE, THERE HAVE BEEN SIGNIFICANT EFFORTS AT REDUCING THE SUPPLY OF DRUGS. BUT AS IS TRUE IN SOME CASES, WE HAVE YET TO REALLY MAKE A NATIONAL POLICY THAT FOSTERS COMPREHENSIVE DEVELOPMENT OF THE RANGE OF SERVICES NEEDED TO EFFECTIVELY DEAL WITH THE PROBLEM. WE HAVE TRIED MANY APPROACHES IN A SERIAL ORDER. WE HAVE TRIED MASSIVE APPROACHES

TO LAW ENFORCEMENT. WE HAVE LAUNCHED AWARENESS CAMPAIGNS. WE HAVE DEVELOPED EFFORTS AIMED AT "DRUG FREE SCHOOLS". BUT IN MOST INSTANCES COORDINATION AND A COMPREHENSIVE APPROACH TO THE PROBLEM HAS BEEN ELUSIVE.

WHEN PAR WAS FOUNDED, IT WAS ORGANIZED WITH THREE DISTINCT COMPONENTS: PREVENTION, EDUCATION AND TREATMENT. OPERATION PAR CAN PROVIDE COMMUNITIES A MODEL FOR THE DEVELOPMENT OF A COMPREHENSIVE APPROACH TO THE DRUG ABUSE PROBLEM. PRESENTLY PAR PROVIDES THE FOLLOWING SERVICES:

OUR PREVENTION SERVICES INCLUDE:

> PRIMARY PREVENTION CURRICULUM FOR FOURTH AND FIFTH GRADE STUDENTS.
>
> INTERVENTION/PREVENTION SERVICES FOR ELEMENTARY AND MIDDLE SCHOOL STUDENTS EXHIBITING BEHAVIORS THAT INDICATE HIGH RISK FOR DRUG USE.
>
> COMMUNITY WIDE PREVENTION EFFORTS SUCH AS "SAY NO TO DRUGS" THAT HELP INCREASE COMMUNITY AWARENESS.
>
> WEEKLY PRODUCTION OF A TELEVISION PROGRAM FOR YOUNG PEOPLE THAT PROMOTES A HEALTHY LIFESTYLE.

OUR EDUCATION SERVICES INCLUDE:

> STRUCTURED EDUCATION EXPERIENCES FOR A RANGE OF GROUPS THAT PROVIDE INFORMATION ABOUT DRUGS ALONG WITH INFORMATION AND GROUP EXERCISES DESIGNED TO HELP DEVELOP HEALTHY LIFESTYLES FREE OF DRUGS.
>
> OUTREACH EDUCATION THAT PROVIDES INFORMATION TO THE ELDERLY ABOUT MISMANAGING THEIR PRESCRIBED MEDICATION.

PAR STAFF HAVE BEEN INSTRUMENTAL IN THE DEVELOPMENT OF A CURRICULUM AT THE LOCAL JUNIOR COLLEGE THAT HELPS TO PREPARE STUDENTS AS PROFESSIONALS IN ADDICTION COUNSELING.

TREATMENT SERVICES INCLUDE:

OUTPATIENT AND SCREENING SERVICES. CLIENTS ARE PROVIDED WITH A WIDE RANGE OF NON-RESIDENTIAL OPTIONS, SUCH AS INDIVIDUAL, GROUP, AND FAMILY COUNSELING, AS WELL AS OFFERING EMPLOYEE ASSISTANCE PROGRAMS AND INTENSIVE OUTPATIENT SERVICES.

DETOXIFICATION SERVICES. PAR PROVIDES ONE OF THE ONLY FREE STANDING MEDICAL DETOXIFICATION CENTERS IN THE BAY AREA.

FOR THE PAST 17 YEARS, PAR HAS PROVIDED LONG TERM RESIDENTIAL TREATMENT SERVICES FOR ADULTS. THE CENTER IS A THERAPEUTIC COMMUNITY WITH A CURRENT CAPACITY OF 100 BEDS AND A WAITING LIST OF OVER 350.

PAR ALSO PROVIDES RESIDENTIAL TREATMENT FOR ADOLESCENTS. THE ADOLESCENT RESIDENTIAL CENTER HAS A CAPACITY OF 30. THIS PROGRAM ALSO HAS A WAITING LIST.

UNDOUBTEDLY YOU HAVE HEARD TESTIMONY OF THE LINKAGE BETWEEN CRIMINAL BEHAVIOR AND DRUG ABUSE. OPERATION PAR CURRENTLY PROVIDES TREATMENT SERVICES IN A SEPARATE WING OF THE PINELLAS COUNTY JAIL. THESE INMATES RECEIVE TREATMENT SIMILAR TO THAT OF THE RESIDENTIAL CENTER DURING THEIR INCARCERATION. UPON RELEASE THEY ARE REFERRED TO THE RESIDENTIAL TREATMENT CENTER.

SINCE ITS BEGINNINGS, OPERATION PAR HAS PROVIDED METHADONE MAINTENANCE. THIS PROGRAM REQUIRES PARTICIPATION IN

COUNSELING AND RANDOM URINALYSIS ARE REQUIRED. THE PROGRAM LEVEL HAS REMAINED RELATIVELY CONSTANT OVER THE YEARS.

OPERATION PAR ALSO OPERATES A URINALYSIS LABORATORY. THE LAB PROCESSES URINALYSIS FROM THE VARIOUS PAR PROGRAMS AND ALSO CONTRACTS IN THE COMMUNITY.

OVER THE YEARS, PAR HAS HAD THE BENEFIT OF NIDA, NIAA, THE DEPARTMENT OF JUSTICE AND EDUCATION AND MOST RECENTLY, SIGNIFICANT ASSISTANCE FROM THE OFFICE OF SUBSTANCE ABUSE PROGRAM PREVENTION OFFICE (OSAP), WHICH PRESENTLY FUNDS THE CHILDREN OF SUBSTANCE ABUSERS PROGRAM. I WOULD STRONGLY RECOMMEND THAT OSAP FUNDING BE INCREASED TO AT LEAST THREE TIMES ITS PRESENT LEVEL. FURTHER, SINCE NIDA IS A RESEARCH INSTITUTE, I WOULD RECOMMEND THAT OSAP BECOME THE OFFICE OF SUBSTANCE ABUSE PREVENTION AND TREATMENT, THUS GIVING A NATIONAL OFFICE FOR BOTH PREVENTION AND TREATMENT.

OPERATION PAR DID NOT DEVELOP A COMPREHENSIVE ORGANIZATION OVERNIGHT. THE GROWTH OF THE ORGANIZATION WAS ORDERLY, BUILDING ON THE KNOWLEDGE BASE DEVELOPED FROM ONE PROGRAM TO ASSIST IN THE DEVELOPMENT OF ANOTHER.

IN RECENT YEARS, PAR HAS CONTINUED TO GROW DESPITE THE REDUCTION OF SOME RESOURCES FOR PUBLIC TAX SUPPORT. UNDERLYING PAR'S STEADY GROWTH HAS BEEN AN EMPHASIS ON DEVELOPING FEE FOR SERVICES PROGRAMS. THESE PROGRAMS PROVIDE OUR COMMUNITY WITH HIGH QUALITY SERVICES AT AFFORDABLE PRICES. PAR CLIENTS ARE CHARGED FOR SERVICES ACCORDING TO THEIR ABILITY TO PAY. NO ONE IS EVER REFUSED SERVICES BECAUSE OF AN INABILITY TO PAY.

ANOTHER UNUSUAL CHARACTERISTIC ABOUT OPERATION PAR IS A TREND TOWARD LESS RELIANCE ON PUBLIC TAX DOLLARS TO SUPPORT THE ORGANIZATION. IN 1981, 97% OF THE PAR BUDGET WAS PUBLIC FUNDS. BY 1987, ONLY 74% OF PAR'S BUDGET COULD BE ATTRIBUTED TO PUBLIC

FUNDS. ALTHOUGH PAR IS RELYING LESS ON PUBLIC FUNDS TO PROVIDE SERVICES, SERVICE LEVELS HAVE NOT DECLINED BUT INCREASED.

ANOTHER IMPORTANT REASON TO INCREASE COMMUNITY BASED TREATMENT OPPORTUNITIES IS THE LINKAGE BETWEEN INTRAVENOUS DRUG USE AND AIDS. WHEN A TREATMENT CENTER LIKE PAR IS EXPERIENCING A WAITING LIST OF OVER 350 PEOPLE DAILY, WE ARE CERTAIN THAT LEFT UNTREATED, THESE PEOPLE POSE A THREAT TO THEMSELVES AND OTHERS. DRUG ABUSERS DO NOT WAIT PATIENTLY FOR TREATMENT. WAITING LISTS CAN OFTEN TAKE MANY MONTHS TO CLEAR. DURING THAT TIME AN UNTREATED IV DRUG USER CAN POSE A SERIOUS HEALTH THREAT WHEN THEIR ONLY MOTIVATION IS TO CONTINUE THEIR ADDICTION. THERE IS SOME THAT DRUG ABUSE TREATMENT DOES WORK. STUDIES CONDUCTED BY THE NATIONAL INSTITUTE ON DRUG ABUSE OVER THE PAST 15 YEARS CONSISTENTLY DEMONSTRATE THAT DRUG ABUSE TREATMENT CAN BE HIGHLY EFFECTIVE IN REDUCING ILLICIT DRUG USE AND CRIMINALITY AND INCREASING DESIRABLE BEHAVIOR, SUCH AS SCHOOL ATTENDANCE AND EMPLOYMENT.

WHEN I WAS PREPARING FOR MY TESTIMONY, I ASKED MYSELF IF I COULD PROVIDE YOU ONE MESSAGE WHAT WOULD IT BE? THE MESSAGE THAT KEPT SURFACING WAS THAT WE CAN WIN THIS BATTLE AGAINST DRUG ABUSE. THE KEY TO OUR VICTORY WILL BE CONSISTENCY AND A COMPREHENSIVE APPROACH.

AT PAR ALL THE DIFFERENT MODALITIES PROVIDE A STRENGTH AND KNOWLEDGE THAT WOULD NOT BE AVAILABLE IF ALL THE SERVICES WERE FREE STANDING. INFORMATION GAINED FROM THE TREATMENT REGIMEN PROVIDE INSIGHT TO PREVENTION AND EDUCATIONAL NEEDS. PREVENTION AND EDUCATION PROGRAMS GIVE US A FEEL FOR THE PRESSURES THAT THE COMMUNITY FACES. IN A SENSE, A COMPREHENSIVE SERVICE DELIVERY SYSTEM PROVIDES THE COMMUNITY MORE SERVICES THAN MERELY THE ADDITION OF SEVERAL PROGRAMS TOGETHER. AS A NEED IS IDENTIFIED BY ONE MODALITY, ANOTHER MAY DEVELOP A SERVICE TO ADDRESS THOSE NEEDS.

FINALLY, IN SUMMARY, I WOULD LIKE TO COMMEND FEDERAL, STATE AND LOCAL INITIATIVES THAT HAVE PROVIDED SUPPORT TO THE INCREASING CRISIS OF DRUG ABUSE. IN ADDITION, I WOULD LIKE TO ENCOURAGE THAT WE CONTINUE TO CHART A COURSE TOWARD VICTORY IN THIS STRUGGLE AGAINST DRUG ABUSE. VICTORY WILL COME FROM A COMPREHENSIVE AND BALANCED APPROACH TO THE ISSUE DRAFTED WITH RESPECT TO COMMUNITY NEEDS. TO BE SUCCESSFUL, WE NEED EFFORTS IN ALL FACETS OF COMMUNITY LIFE; LAW ENFORCEMENT, PREVENTION, SCHOOLS, PARENTS, BUSINESSES, THE MEDIA AND CHURCHES. WE ALL HAVE A RESPONSIBILITY TO ASSURE A DRUG FREE COMMUNITY. THE EFFORTS MUST BE COMPREHENSIVE AND BALANCED. WE MUST NOT FORGET OR SHORTCUT TREATMENT IN FAVOR OF PREVENTION. AT THE SAME TIME, WE CANNOT BE SUCCESSFUL IF WE FOCUS ALL OUR EFFORTS ON PREVENTION AND IGNORE THE NEEDS OF TREATMENT OR ENFORCEMENT. IT IS TIME THAT EACH AND EVERY AMERICAN TAKE A PERSONAL ASSESSMENT OF THEIR CAPACITY TO ASSIST IN THE STRUGGLE AGAINST DRUG ABUSE. AS PROFESSIONALS AND LEADERS IT THEN BECOMES OUR RESPONSIBILITY TO DEVELOP A COMPREHENSIVE APPROACH TO THE PROBLEM THAT WILL ALLOW US ALL TO BECOME A PART OF THE SOLUTION.

IN RECENT MONTHS THERE HAS BEEN SOME DISCUSSION ABOUT WHETHER THE UNITED STATES IS COMMITTED TO WINNING THIS WAR ON DRUG ABUSE. I CAN TELL YOU THAT THE KNOWLEDGE AND PROGRAMS AND PROFESSIONALISM IS AVAILABLE TO WIN THIS WAR. WE NEED TO DECIDE IF IT IS A WAR WE TRULY ARE COMMITTED TO WINNING. ORGANIZATIONS THROUGHOUT THIS COUNTRY HAVE REFINED TREATMENT AND PREVENTION TECHNIQUES THAT ARE AVAILABLE. WINNING THE WAR WILL EXACT A COST, INCREASING THE RESOURCES NECESSARY TO DO THE JOB WILL BE EXPENSIVE. HOWEVER, A DECISION NOT TO COMMIT THE RESOURCES WILL ALSO EXACT A HIGH PRICE ON SOCIETY.

WE NEED TO DECIDE THE LEVEL AND EXTENT OF OUR COMMITTMENT IN PROTECTING OUR NATURAL RESOURCES, OUR COMMUNITIES, FROM DRUG ABUSE. THERE ARE NO QUICK FIXES, BUT THERE CAN BE A SOLUTION. THE SOLUTION WILL COME WHEN THE LEVEL OF RESOURCES COMMITTED TO

FIGHT THE DRUG ABUSE PROBLEM IS IN PROPORTION TO THE PREVALENCE OF THE PROBLEM.

IN A FEW SHORT WEEKS, AMERICANS WILL CELEBRATE ONE OF OUR MOST TREASURED HOLIDAYS, INDEPENDENCE DAY, THE FOURTH OF JULY. ON THIS DAY WE CELEBRATE OUR FREEDOM. BUT SOMETIMES AMIDST THE FIREWORKS, PICNICS AND CONCERTS IT IS EASY TO FORGET THE PRICE WE PAID FOR OUR FREEDOM. WE ALSO TEND TO FORGET HOW FRAGILE THAT FREEDOM IS.

TODAY IN THE UNITED STATES, THE FREEDOM OF MANY AMERICANS IS THREATENED DAILY. ONE OUT OF EVERY TEN OF US LOSE OUR FREEDOM TO THE TYRANNY OF DRUGS. THE THREAT THAT DRUG ABUSE POSES FOR OUR COUNTRY IS REAL - LOST POTENTIAL, DROPOUTS, RUNAWAYS, DISINTEGRATION OF THE FAMILY, CRIME, THE LIST GOES ON AND ON, DRUG ABUSE COSTS INDIVIDUALS THEIR FREEDOM.

WE NEED TO PROTECT OUR FREEDOM. WE NEED TO CONTINUE THE STRUGGLE AGAINST DRUG ABUSE. THIS IS A LONG BATTLE. THERE ARE NO QUICK FIXES. OPERATION PAR WAS FOUNDED ON THE BELIEF IN INDIVIDUAL RESPONSIBILITY, OUR NAME PARENTAL AWARENESS AND RESPONSIBILILTY REFLECTS OUR COMMITTMENT TO DO WHAT WE CAN TO IMPROVE THE QUALITY OF LIFE IN OUR COMMUNITY BY MEETING THE NEEDS OF DRUG ABUSE.

CLARENCE DARROW WAS ONCE QUOTED AS SAYING, "YOU CAN ONLY PROTECT YOUR LIBERTIES IN THIS WORLD BY PROTECTING THE OTHER MAN'S FREEDOM." WE NEED TO CONTINUE TO PROTECT OUR COMMUNITIES FROM THE DEVASTATION OF DRUG ABUSE THROUGH A COMPREHENSIVE AND BALANCED APPROACH ENCOMPASSING ALL FACETS: LAW ENFORCEMENT, PREVENTION, AND TREATMENT.

THANK YOU.

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COMMENTS BY MRS. SHIRLEY D. COLLETTI

The following comments are prepared in response to questions by Senator Hatch for Mrs. Shirley Coletti following her appearance before the Committee on Labor and Human Resources.

1. Some critics of treatment programs have indicated that the success rate for treatment is not very high. What is the rate of success in your treatment program and other therapeutic communities?

   A very important measure of success concerns the extent to which individuals remain drug-free and socially productive following the conslusion of treatment. We have conducted several brief studies to examine the success over time of Operation PAR's therapeutic community treatment programs.

   Of all individuals completing treatment at PAR's adult Therapeutic Community, approximately 80% remain drug free and productive. In a study conducted by the Florida Department of Corrections of 100 prison inmates who were treated at PAR's Therapeutic Community over a 13 year period, 77% were not recommitted to the Florida prison system. The study also revealed that of the inmates who did not complete the residential treatment program, 75.4% were not recommited to prison. These data clearly illustrate the success of the program in keeping convicted felons from returning to prison.

   At PAR's Adolescent Residential Center, which is based on the therapeutic community model, in a follow-up study of all teenagers who completed treatment during 1987, 92% were drug-free and considered successful. The criteria for success includes abstinence from drug or alcohol use, being in school, employed or actively seeking employment, refraining from delinquent or criminal activity, and maintaining socially appropriate family and peer relationships.

   Beyond these few studies, of which we certainly need more, our anecdotal experience confirms that a very high proportion of the individuals who complete treatment remain drug-free and socially productive. I also believe that the success rates illustrated at our programs are reflective of the success of rates of other long-term, therapeutic community treatment programs, as reported in the drug abuse professional literature.

2. What percent of those who start a treatment program like PAR complete it on the first attempt?

The proportion of all individuals who enroll in and complete residential treatment somewhat varies from year to year. We do not have data on who completes treatment on the first attempt. At PAR's Therapeutic Community, the completion rate is approximately 20%. At PAR's Adolescent Residential Center, 25% of all teenagers complete treatment.

3. Do you feel that early intervention can be successful in overcoming the role model of drug using parents?

We must take a comprehensive approach to early intervention efforts. I support these efforts and believe we must do much more in this area. I believe that early intervention efforts targeting the children of substance abusers can be helpful in decreasing the risk that these children may themselves grow up to become substance abusers.

We must remember that children whose parents are substance abusers have been found to suffer disproportionately from a wide variety of problems including developmental delays, poor school performance, increased health problems, low self-esteem, poor peer relations, a wide variety of emotional and personal problems, and higher risk of future alcoholism and drug abuse, to name a few. The issue is not simply poor parental role modeling. The issue centers around chemically dependent parents who are unable to provide appropriate nurturing, care and support for their children. Simply put, chemically dependent parents are not only poor role models, they are also poor parents.

I believe that early intervention programs which target not only the child but also the parent have the greatest likelihood of succeess. These programs are essential and their development should be encouraged.

17:31

The CHAIRMAN. All of those programs which have been proved on the basis of scientific merit, we are going to recommend funding for all those programs. I think you make a good point.

Mr. Mactas.

Mr. MACTAS. Good morning. Thanks very much for the opportunity.

I am not going to read my comments, and I apologize as a public speaker; I am a great clinician. But I will persevere. The last time I had the pleasure of testifying before a Senate Committee, I was also the last witness. The first witness was Elizabeth Taylor. And I have had just enough time for my ego to be mended somewhat, and I appreciate the opportunity to have to do that again for next year. But the intimacy is nice, and again I appreciate the opportunity.

I have been in the field for 22 years. My organization, Marathon House, just celebrated its 20th anniversary. My priority this morning are those who rely on Government subsidy for access to treatment. Over-representation in that contingent is by the indigents and minorities in this country. And I know you will forgive me if I convey the skepticism of both treatment professionals and those in treatment, relative to the lexicon that we have adopted—"war on drugs".

This is a war on drugs that follows all the wars and the battles and arguments and disagreements and spats of previous Administrations. I think people forget, under the Carter Administration, there was a top-secret CIA document called "Operation Cerberus", which was an exercise toward uncovering the metric tonnage of heroin that came across these shores from Iran, Pakistan and Afghanistan under the Carter Administration.

After that report was published, the treatment budget was cut. Before the advent of the block grant configuration of funding, there was $630 million allocated for alcohol, drug abuse and mental health services. And here we are, about nine years later, and we've got about $630 million for the same services.

So, when accounting for inflation, albeit small, we haven't come a great distance—and this is on the heels of all of the wars and the battles.

In addition to the wars and the battles, part of the problem for us in the field, those who have devoted careers to this business, is the parlance of the military engagement. The language is very often unfortunate, because what it overlooks is the sensitivity, the nuances and subtleties of treatment, the nuances and subtleties of the plight of those who attempt to reclaim a sense of personal autonomy and human spirit. That is unfortunate as well. And the goal for me this morning, as it has been for many people, is not only to commandeer the requisite dollars, but also to commandeer the requisite compassion. And I think to a great extent we are singing to the choir this morning, because your leadership is exemplary, as many Members of your Committee.

Even the notion of a "drug czar" conjures up the image of Cossacks going out with sabers poised, to fight the wars.

As Dr. Newman cites and many other people cite, we are here with some good news, too. There are victories, if indeed we can call them that, on the clinical front. We are making great, great strides in this regard.

My own agency, while I won't spend much time talking about Marathon House, is primarily a therapeutic community and operates a network of facilities throughout New England, and we are very proud to have two facilities in the Commonwealth.

The average cost per day is just over $40, and that includes housing, shelter, food, clothing, transportation, 24-hour-a-day coverage and counseling—just over $40 a day, which is probably the cost of a Motel 6.

The reimbursement we get on the average in New England is $28 a day. The reimbursement is not very good, and what it leads to is not only taking people out of their clinical roles toward fundraising; it makes presidents of organizations go for licenses—I am a licensed auctioneer; that's how I am used to raise money for the organization as well. And as an auctioneer, I am a very good clinician.

The waiting list, as has been referenced, is very, very critical. While my own organization has a waiting list of five months, the average for therapeutic communities nationwide is eight months.

We also heard this morning that intravenous drug users constitute the most virulent conduit of AIDS into the heterosexual community. The public health concern for AIDS is providing a great impetus and a great opportunity for us to start talking about treatment on demand. And it is not only treatment on demand that I am concerned with; it is free choice. In other words, I am concerned that people not be steered to specific treatment, but be afforded free choice. And I am on a number of commissions and committees in Washington, and the notion and the perception of the addict nationwide tends to be very stereotypic, and tends to imbue the addict with the inability to make free choice, someone who is too often crazed by his or her passion for drugs and unable—and irretrievable in that regard—and unable to exercise free will. And as has been noted before, there are addicts who are exercising free will. An example is the Chairman of my own Board of Directors, who himself is an ex-addict, a graduate of a therapeutic community, and a practicing physician.

I am handed a note, and I am disarmed by it. But what I am being reminded of is relative to current proposed legislation, we need in order to expand the drug-free option for treatment in this country to understand that there must be funds set aside for capital construction. We cannot expand presently the network of drug-free programs nationwide. We are already over-capacity and many of us in violation of building, health, fire and safety codes.

Moreover, we need stability of funding. We need to know that, year-in and year-out, there is a commitment on the part of the Federal Government, because we cannot expand physical plant and all of the capital that is involved in the expansion of physical plant if we have to fight again next year and the year after and the year after. I don't think we are going to see in the near future the elimination of drugs. The parlance of "drug-free America," "drug-free public housing," I think, are terms that doom us to failure. I think what society needs from us is some positive impact, and they are willing to accept positive impact at an interval basis year after year after year. And I think we can demonstrate that, but we need your understanding and support.

Thanks again. I appreciate it.

[The prepared statement of Mr. Mactas, responses to questions of Senator Hatch by Mr. Mactas, and additional material submitted for the record follow:]

Testimony of

David J. Mactas

President

Marathon House, Inc.

presented to

United States Senate

Labor and Human Resources

Committee

June 16, 1988

My name is David J. Mactas. I am grateful for the opportunity to present this testimony before The Committee.

I am President of Marathon House, Inc. Now in its 21st year, Marathon House operates seven residential treatment facilities in four New England states. Moreover, we were selected to administer a $2.5 million AIDS outreach demonstration project under the aegis of the National Institute on Drug Abuse.

Given the leadership and composition of the Committee, it is indeed difficult to offer new insights. However, with your indulgence, I will attempt to convey a perspective which may reflect, to some degree, the spirit of my colleagues in the Service Provider community.

It is 1988, and there is a War on Drug Abuse - on the heels of the battles, skirmishes, spats and misunderstandings of previous crusades. That the drug abuse problem is one which continues to undermine our social fabric, is evident. What is clear, as well, is society's frustration with its perceived inability to stem the tide.

Our responses to this sense of powerlessness are indeed intriguing. The language of the mass media and political rhetoric in successive election years reflect the language of military engagement - interdiction, property seizure, drug bust, etc. Such parlance is in stark contrast to the overly simplistic bumper sticker strategy of "Just Say No". Tragically, while public attention is drawn to either one orientation or the other, the subtleties and nuances are neither understood nor considered. It is on this middle ground that a significant battle is being fought with victories every day. This is the treatment "arena".

As we all know, addiction is a phenomenon which cuts across all strata of society. Chemical dependence is the great equalizer. However, it is my concern for those who rely on government subsidy for access to treatment that motivates the present testimony. It is this contingent which faces the greatest crisis at this point in time.

Incidence and prevalence data for indigents and minorities are staggering. Intravenous drug use has spread from the inner city ghetto across the length and breadth of this nation, and constitutes the single most virulent conduit of AIDS into the heterosexual community.

In the absence of some form of clinical intervention, the course of addictive behavior by this group is interrupted only by death, serious illness, or prison. Those costs, both social and monetary, associated with the above are formidable indeed. Lost wages and resultant diminution in taxes, adjudication and incarceration, and health care outlays continue to drain the public's coffers. However, there is good news. Treatment works.

Marathon House's adult residential treatment programs are built on the Therapeutic Community model. This approach emphasizes self-help and work ethic. It recognizes our capacity to heal our own wounds, while assisting peers in the process of achieving a drug-free self-sufficient lifestyle. It represents a treatment orientation cited by the National Institute on Drug Abuse as having "the most successful outcomes" for that group often described as the "hard core".

I am past President of Therapeutic Communities of America, a consortium of some three hundred facilities with over 8,200 people in residence. Over 82,000 people are served annually by these agencies through the multiplicity of services provided.

The average cost of drugs per day, per client is approximately $145.00. When viewed against the number of residential and outpatient clients seen per day by this coalition (17,300), we recognize that were it not for treatment, over $2.5 million dollars per day would be expended in this regard. On an annual basis, this figure approaches $1 billion.

Services in Marathon House, as other therapeutic communities include, housing, food, counseling, education, recreation, family therapy, 24 hour supervision, etc. The cost per client is just over $40 per day. The economies are apparent.

While this figure is low by any standards, not one of our state contracts provides even this level of reimbursement. Therefore, a significant percentage of available time is dedicated to fundraising - time better spent on clinical services. In short, we are no better able to support our efforts than we were during the Lyndon Johnson Administration.

The Marathon House residential program lasts about one year. Observation and urine surveillance insure that there is no drug use while in the program. Although half of our admissions are criminal justice referrals, there is virtually no criminal activity while in treatment.

Most applicants present cocaine as the primary drug of abuse, with heroin second. There is, as a rule, a history of needle use.

Although just 5-7% are employed at time of admission, 60% are working full time at one year follow-up after discharge. With respect to drug use, 60% have completely eliminated and 20% have significantly reduced such activity at one year following discharge. Legal contact data are not as encouraging, with 30% reporting no such interaction at one year. It should be noted that for those who graduate, 85% will remain drug-free criminality-free and self-supportive at one year.

Facility Directors at Marathon House have been in their positions on an average of seven years. As their respective staff, they are dedicated professionals whose careers are invested in drug treatment. To collaborate in that process where clients grab hold of their destinies and reclaim both spirit and direction, is indeed uplifting. Insulated from political fickleness and funding exigencies, they persevere.

Unfortunately, the ability of the treatment network to respond to increasing demand continues to be encumbered by overcrowded facilities and interminable waiting lists. Addicts do not fare well on lists. In one ten day period at Marathon House, 14 of those addicts on our waiting list who were called for admission could not be located. They have sought out clinical intervention and were turned away. Attempts to refer them elsewhere at first contact, were futile. At present, there is a four month wait.

The AIDS crisis is the impetus behind much discussion of intravenous drug use. Debates over legalization, needle exchange, mandated treatment and death penalty have ensued. Inadequately addressed is the issue of "access to treatment".

The trend nation wide is to expand those programs which dispense methadone. This is a prudent strategy only in the context of an overall approach which permits free choice.

It is my view that, given the paucity of drug-free alternatives, indigents and minorities are being steered into chemotherapy, where another course may be clinically indicated. Moreover, this approach is appropriate only for opiate users. Most needle using addicts do not use opiates. Hence, they are not eligible.

In the absence of some form of clinical intervention, the course of addictive behavior by this group is interrupted only by death, serious illness, or prison. Those costs, both social and monetary, associated with the above are formidable indeed. Lost wages and resultant diminution in taxes, adjudication and incarceration, and health care outlays continue to drain the public's coffers. However, there is good news. Treatment works.

Marathon House's adult residential treatment programs are built on the Therapeutic Community model. This approach emphasizes self-help and work ethic. It recognizes our capacity to heal our own wounds, while assisting peers in the process of achieving a drug-free self-sufficient lifestyle. It represents a treatment orientation cited by the National Institute on Drug Abuse as having "the most successful outcomes" for that group often described as the "hard core".

I am past President of Therapeutic Communities of America, a consortium of some three hundred facilities with over 8,200 people in residence. Over 82,000 people are served annually by these agencies through the multiplicity of services provided.

The average cost of drugs per day, per client is approximately $145.00. When viewed against the number of residential and outpatient clients seen per day by this coalition (17,300), we recognize that were it not for treatment, over $2.5 million dollars per day would be expended in this regard. On an annual basis, this figure approaches $1 billion.

Services in Marathon House, as other therapeutic communities include, housing, food, counseling, education, recreation, family therapy, 24 hour supervision, etc. The cost per client is just over $40 per day. The economies are apparent.

While this figure is low by any standards, not one of our state contracts provides even this level of reimbursement. Therefore, a significant percentage of available time is dedicated to fundraising - time better spent on clinical services. In short, we are no better able to support our efforts than we were during the Lyndon Johnson Administration.

The Marathon House residential program lasts about one year. Observation and urine surveillance insure that there is no drug use while in the program. Although half of our admissions are criminal justice referrals, there is virtually no criminal activity while in treatment.

In order to insure a diversity of available services and free choice, federal and state governments must first recognize that these clients are citizens who deserve an opportunity to achieve rehabilitation.

Too many hold the view that all addicts are dangerous, disease carrying, irretrievable and undeserving of our compassion.

I have heard it said that addicts are victims of a disease and unable to exercise free will, that they are consumed by their passion, and must be divested of personal responsibility. Others hold that our only salvation lie in heightened enforcement and punishment. — It is time for stereotype and indignation to yield to understanding and perspective.

The emergence of the Therapeutic Community in the 1960's was testimony to the inability and unwillingness of the mental health and psychiatric communities to deal with the problem of drug abuse. As this phenomenon moved up through the social strata and across racial boundaries, insurance coverage broadened with the promise of profits. While capitalism and quality services are not mutually exclusive, the "marketplace" is permeated by those who rejected this specialty scant few years before. Experts abound.

There is, clearly, a two-tiered system of care, with little exchange of either interest of knowledge. While treatment may be tailor made for the "haves", the "have nots" are matched to that treatment which is available - "Where can I find a bed?" Humane, if not scientific.

As congress debates various legislative initiatives, it is not my mission to exploit this platform to advocate additional resources. This Committee, and others, recognize the relative scarcity of resources. Rather, it is my goal to reinforce the need for stability of funding. In addition, it is time for us to acknowledge and appreciate the complexity of this dire social and personal tragedy.

Drug abuse is an area which seems to bring out the oratory in all of us. There is much to learn, and many who can teach.

"Just Say No" is an example of a campaign which, I believe inures to the detriment of the field. It trivializes both the problem and the individual. Moreover, it is another glitzy piece of marketing - another cause celebre.

I am convinced that "Just Say No" will go down in history as having as much impact as "Have a Nice Day" buttons had on clinical depression!

Again, I am grateful for the opportunity to appear before the Committee, and look forward to the chance to report on progress at future deliberations.

Marathon House

MARATHON HOUSE, INC.

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LAWRENCE KAHN, CPA, Vice Chairman
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July 5, 1988

Hon. Edward M. Kennedy, Chairman
United States Senate
Committee on Labor and Human Resources
428 Dirksen
Washington, DC 20510-6300

Dear Senator Kennedy,

I am in receipt of your letter of June 20, as well as some questions raised by Senator Hatch.

His first question is prefaced by a statement that some critics hold the view that the success rate for treatment is not very high. Until a universal definition of success is codified, it will be difficult to convey the very positive impact of treatment. However, there are some data which should illuminate the efficacy of the Therapeutic Community approach.

Marathon House, founded in 1967, operates the largest network of therapeutic communities in New England. The majority of our clientele are cocaine and/or heroin abusers, most of whom are at risk for AIDS by virtue of a history of intravenous use.

Over the last quarter century, we have learned that successful outcomes are directly related to length of time in treatment. The data for those who complete program are indeed noteworthy.

Followed seven years after treatment, 75% of program completers are deemed successful. Approximately 50% of those who remain a year or longer in residence are successful across all years of follow-up. The most favorable outcomes are for opiate addicts(DeLeon, 1986).

In a NIDA research monograph published in 1985, Hubbard reports that 94% of clients claimed reduction in drug use as a result of therapeutic community treatment.

As addressed in my testimony before The Committee, only 5-7% of Marathon House clients are employed at time of admission. At 12 month follow-up post treatment, 60% are employed full time-7% part time.

a place to change and grow

With respect to drug use, 60% have completely eliminated, and 25% significantly reduced at 12 month follow-up.

Question #2 in your mailing asks the percentage of those that complete treatment on their first attempt. I would estimate 13%. It should be noted that addiction is a phenomenon characterized by relapse.

It is, I think, important to stress that graduation is a prerequisite for neither success nor positive impact. A high percentage of "dropouts" do well. Moreover, "graduation" is unfortunate parlance which, too often, overlooks significant clinical intervention.

I do appreciate the opportunity to address these points, as well as your ongoing leadership and interest in this regard.

Sincerely,

David Mactas

David J. Mactas
President

DJM/hyr

Guest Editorial
for Submission to Newsweek's "My Turn"

Time for a New Look at Our National Strategy on Drugs

Sometimes societies are slow to learn; and I contend that ours has been exceptionally slow to learn in dealing with its drug problems. For years now we have been throwing increasing billions of dollars into our effort to slow the supply of drugs--particularly cocaine. For those same years the supply has risen steadily--again, particularly for cocaine. Cocaine costs less on the streets of America today than at any time in recent history, and the average purity is higher, too, according to Drug Enforcement Administration statistics. The annual High School Senior Survey shows a higher reported cocaine availability by seniors in 1987 than in 1986, or anytime before. Clearly the war on drugs is being lost on the battlefield of supply reduction.

At the same time, there have actually been some improvements in the usage situation--despite the increased supply--as American high school seniors, college students, and young adults in their twenties (who are high school graduates), all showed a marked decline in cocaine use in 1987. Since the decline clearly did not occur as the result of reduced supply, by deduction it must reflect reduced demand; and a little closer look suggests strongly that changed beliefs and attitudes about cocaine are behind these changes in use. For the first time in more than a decade there was an increase in the number of these adolescents and young adults who thought experimenting with cocaine was dangerous. Much the same thing has been happening with marijuana use over the past decade--perceived risks and disapproval have been rising and, largely as a result, use has been falling. Probably many segments of society deserve a share in the credit for these modest improvements--schools, parents, the media, scientists, government, and young people themselves.

Of course, we still have a very long way to go on both drugs, as well as all the others in our pharmaceutical cornucopia; but the point is that demand reduction can work and has shown evidence of working, even with an extremely modest financial investment and in the face of increasing supply. This, in fact, is almost surely the only battlefield on which we can win the war on drugs. Most of the leaders in law enforcement have themselves said it flat out: they cannot win the war, the best they can do is a holding action; and the evidence is that, despite Herculean efforts they cannot even do that. But we seem to be having trouble accepting that message, and incorporating it into our national strategy, since all we seem to hear is calls for more money to be spent on what didn't work in the first place--efforts to control the supply. The Congress just voted to throw U. S. military forces into the fray, no doubt at a cost of some additional billions per year, although those costs will be hard to account in the massive defense budgets. If we are lucky that will increase the proportion of cocaine interdicted from 10% to perhaps 15% or 20%, the suppliers will increase the total being shipped, and we will be right back where we started in terms of cocaine delivered to the American market.

Why can't we win the war on the supply battlefield? For the simple reason that there is an almost endless supply of suppliers. Take the case of supplier countries. Many of those countries with which we already have good relations are not in control of major regions of their own territory. Opium and cocaine, after all, tend to be grown in remote, mountainous regions. (Remember that our own country is a major producer of marijuana; if we cannot control production successfully within our own borders, is it realistic to expect other countries to do so? And we do not have the threat of insurgency groups in the growing areas, as do producer countries like Burma, Thailand, Columbia, and Peru.) That's not to say that those governments couldn't be doing more; just that it is unrealistic to expect them to be totally successful at eliminating production. But even if they could, there are plenty of countries not within our sphere of influence who can come in to take their place: Iran, Afghanistan, Cambodia, Laos, and Lebanon, not to mention all of the Communist bloc countries in Europe, a number of which already serve as transhipment countries. In the case of cocaine it is estimated that at least 17 countries have the conditions necessary for production.

But in the even more unlikely event that we could get all countries in the world to stop the production of crops which yield natural drugs (like coca, opium and cannabis), there are a great many chemists available to make cheap substitutes. We have already seen it with heroin analogues and synthetic hallucinogens, like LSD and PCP. The same can be done for cocaine. Can we also gain worldwide control of all the chemists? This is a futile exercise.

And production is only part of the uncontrollable supply system: importation and distribution are the others. Right now cocaine reaches this country largely through the efforts of the hydra-headed Medellin Cartel. When we cut off one of the heads last year in the person of Carlos Leder, who was extradited to the U. S. by Colombia and is about to be put away for a long time, there was not even a ripple in the inflow of cocaine. Nor will there be one if we manage to replace Manuel Noriega with honest Panamanian leadership. There are a great many routes to the U. S., and big money can always open up a replacement route, usually with government officials along the new route becoming complicitous. The cost for us, and more importantly for these neighboring countries, is that their governments will become more tainted in the process. In the long run this will constitute a large and particularly tragic part of the human toll taken by America's fascination with drugs. Legitimate democracies take a long time to build, a short time to corrupt and erode.

The simple fact is that as long as the American market for drugs remains as enormous as it is, there will be vast profits to be made at all stages of production and distribution; and there will be an endless supply of countries, cartels, and individuals willing to take the risks necessary to make that kind of money. That doesn't mean that we should take the heat off of them, and lower their risks. It just means that we shouldn't be misled by the satisfaction we derive when one of them gets caught, or by the widespread publicity which accompanies each big seizure, into thinking we have made progress in winning the war. For every two steps forward, we have slid back three. For every pound of cocaine seized, nine got through. The fact is that even if we double or triple or quadruple our expenditures on interdiction, we still cannot effectively control thousands of miles of border being crossed daily by vast numbers of ships, aircraft, products and people. And no matter how much we increase expenditures for domestic enforcement, there will always be new dealers ready to step forward while the apprehended ones cool their heels in prison for awhile. And we can't build new prisons fast enough to keep up with the supply of new dealers. All we will succeed in doing is making ourselves more frustrated and more willing to consider radical solutions, like legalizing drugs or giving up some of the civil liberties so many of our forefathers gave their lives to defend, in an ever more desperate attempt to control the drug problem. Increasingly we are hearing these desperate calls--they are starting to attain some legitimacy. Frankly it scares me, and all the more so when I think about the fact that most of them won't work either. In fact, some are likely to make the drug problem considerably worse.

That leaves us with the stark reality, then, that to win the war on drugs we must win it on the battlefield of demand reduction--more specifically, by changing young people's attitudes, beliefs, and social norms, and by increasing parental control, community control and community action. We also need to deal with opportunities for young people, provide counseling and other early interventions, develop effective media campaigns, and so on. These are not very glamorous, mind you, and the media gives them practically no attention--since they are almost devoid of good photo opportunities--but they are the things which have by far the greatest potential to make a difference and to make a lasting difference.

Maybe you assume all of that is going on anyway. Well, some of it is in a partial, haphazard, patchwork sort of way. But for the most part, serious demand reduction activities are not occurring in most communities in this country. And one of the reasons they are not is because there hasn't been either serious or sustained funding for demand reduction during all these years of the drug epidemic. Another central reason is that the knowledge base upon which we can build these prevention activities is, in general, weak--and that is so because the relevant research which might have been going on for the past twenty years has received less than nominal funding, and continues to receive less than nominal funding even today, and even under the proposals before the Congress for future funding as far as I can see.

We do not have any "think tanks" to enlarge and improve the portfolio of approaches to prevention we should consider; and we should. We do not have any major research centers responsible for evaluating what's being done, so that we can stop wasting time on the ineffective approaches and widely disseminate the effective ones; and we should. (The few individual research projects of this type we have are under-funded and getting funding cuts.) We do not have a national program to mobilize community action or to provide models and technical assistance so that communities can proceed with some confidence and direction: we should. The National Institute on Drug Abuse currently can fund only about one-fifth of the research grants it receives which are scientifically approved as meritorious, and even to do that they are cutting all existing research grants in the drug abuse area by five percent or more this year--a practice which has become commonplace in recent years. As I have argued, as a member of the National Advisory Committee on Drug Abuse, this policy of persistent across-the-board cuts is going to leave us with a stable full of three-legged racehorses.

Could we be doing more in the area of prevention? Vastly more. Could the school curricula most children are receiving be improved? A great deal, for those children receiving one: one-fourth of them say they don't receive any. Could communities be doing more to mobilize around this issue? Absolutely. They need some help getting going and some successful, or at least promising, models to follow.

So, are we taking the problem of demand reduction--our best hope at winning the war on drugs--very seriously? Not very, it would seem. Maybe we'd better rethink our strategy and stop pouring ever greater resources into the battlefield where we are bound to lose the war, while paying little more than lip service to the battlefield where we can win it. We need a major realignment in our federal strategy, in particular, and in our state and local ones as well.

Lloyd D. Johnston

The **Chairman**. That is very, very helpful. We have our Marathon House, as you well know, up in Springfield. Vincent Tobin is the Director up there; and out in Walpole, and I know they would certainly support all of the things you have pointed out.

I am very grateful to all of you and the witnesses we have had today. I had the chance to attend the Armed Services Committee hearing yesterday, talking about the role of the military; and we had some earlier hearings with regard to the Judiciary as to programs that have had some success in dealing with the crisis in local communities. But we find that by and large, at least the law enforcement personnel that we have had, come down and support the things which have all been stated here today—the Secretary of Defense does, the Armed Services Committee, the law enforcement personnel, and those who have been out on the front lines, such as yourselves, for a long period of time.

And if there is a concluding note to these hearings, it is that there is some good news. I think Mr. Mactas has said it explicitly, and I think that is a good way to wind up this hearing. I think the country is alarmed, families are alarmed, elderly people are alarmed, and the Congress has been reacting in a rather frenetic way—but I think the panels today have given us some very important insights about what can be effective and have reminded us that this is going to be a long haul, and that we had better prepare the American people for it, and that it is going to take some trial and error, but there certainly are some things that are out there that do work, and we have been very fortunate to have people today who have brought those to our attention.

We'll go over the record carefully, and I am sure we will be back in touch with all of you as we move on through the time ahead. I am sure I can say for my colleague, Senator Moynihan, Dr. Newman, a warm word of welcome to you. And I know, Ms. Coletti, I can give you a warm word of welcome from Senator Chiles. We have had some hearings, and he has been a very important figure in terms of priorities. Mr. Mactas, you are a neighbor up there in Rhode Island, so we want to say a warm word of welcome to you, I am sure from Senator Pell and Senator Chafee and my other colleagues.

The Committee will stand in recess. Thank you.

[Whereupon, at 1:12 p.m., the Committee was adjourned.]

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